Granite Hills Dental Team

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name:
Address:
Telephone:

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice IS in the reception room and you may request a copy be emailed to you. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Granite Hills Dental Team 810-104 Jamacha Rd El Cajon, CA 92019 (619)579-0233

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

PLEASE LIST NAMES:

_____

I hereby give my consent to Granite Hills Dental Team to discuss my treatment and finances involved in it with above named person/persons

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY OR EMAIL

I,_____, have received acknowledgement of this office's Notice of Privacy Practices and agrees to them.

_____ January 9, 2019 **(BOOKLET AT FRONT DESK)**
SIGNATURE PATIENT/PARENT

PATIENT/PARENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET.

You have been offered a booklet, "The Facts About Fillings" . This dental materials fact sheet is made in an effort to assist you in understand the materials used in dentistry and their risk, benefits and alternatives.

_____ January 9, 2019 **(BOOKLET AT FRONT DESK)**
SIGNATURE PATIENT/PARENT

For Office Use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
☐☐____ Individual refused to sign
☐☐____ Communications barriers prohibited obtaining the acknowledgement
☐☐☐____ An emergency situation prevented us from obtaining acknowledgement
☐☐☐____ Other (Please Specify)
_____
_____

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: ____ Family Status: _____ Social Security #_____Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell)_____

E-mail Address: _____

*I agree to allow the office to contact me by email and forward my x-ray's to other providers as deemed necessary*_____ ☐
Initials please

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit:_____ Reason for this visit: _____

AIDS	Y	N	Fainting	Y	N	Seizures	Y	N	Excessive Bleeding	Y	N
Anemia	Y	N	Head Injuries	Y	N	Respiratory Problems	Y	N	Prostate Trouble	Y	N
Arthritis	Y	N	Heart Problems	Y	N	Rheumatic Fever	Y	N	Dry Mouth	Y	N
Artificial Joints:	Y	N	Heart Murmur	Y	N	Sinus Problems	Y	N	Severe Headaches	Y	N
Date Placed_____			Mitral Valve Prolapse	Y	N	Stroke	Y	N	**Allergies**: List	Y	N
Asthma	Y	N	Hepatitis	Y	N	Substance Abuse	Y	N	_____	Y	N
Cancer	Y	N	High/low Blood Pressure	Y	N	Thyroid Condition	Y	N	_____	Y	N
Chemo/Radiation	Y	N	Kidney Disease	Y	N	Tuberculosis	Y	N	**Pregnancy**: Due		
Circulatory Problems	Y	N	Liver Disease	Y	N	Herpes/Shingles	Y	N	_____		
Diabetes	Y	N	Mental Disorders	Y	N	Fever Blisters	Y	N	Osteoporosis?	Y	N
Difficulty Breathing	Y	N	Nervous Disorders	Y	N	Radiation Treatment	Y	N	Latex allergy?	Y	N
Emphysema	Y	N	Pacemaker	Y	N	Epilepsy	Y	N			

Have you had all recommended vaccinations? ☐ Yes ☐ No

Emergency Contact Name/Phone _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  - **List Current Medications you are now taking including any over the counter drugs:**

Name of Physician: _____ If Kaiser MR#	Phone:

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Insurance ID or SSN #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. **A 48 hour notice of change or cancellation is required**. **Patients failing to give 48 hour notice are subject to a $40.00 charge**.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I authorize release of information to my insurance company and authorize their direct payment to your office.

I give my consent to all agreed upon dental treatment for myself or dependent. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party