Redlands Dental Surgery Center

1180 Nevada Street, Suite 100
Redlands, CA 92374
(909) 335-0474

Patient Information

Last Name: ______________________________ Home Phone: ____________________

First Name: ___________________ M.I. _____ Mobile Phone: ____________________

Street Address: ____________________________ Date of Birth: __________ Age: _____

______________________________________ Sex (M/F): ____________________

City: _________________________________ Social Security: __________________

State: _____ Zip Code: ____________________ Marital Status: **M S W D Sep**

Is the patient a participant in the California State Benefits Program (Medical/Dentical)?

Yes – ID# ____________________

No – Please complete the following information: Email: ___________________________

Health Insurance: _________________________ (Kaiser, Health Net, LA Care)

Insurance Subscriber Information

Last Name: ______________________________ Home Phone: ____________________

First Name: ___________________ M.I. _____ Mobile Phone: ____________________

Street Address: ____________________________ Date of Birth: __________ Age: _____

______________________________________ Sex (M/F): ____________________

City: _________________________________ Social Security: __________________

State: _____ Zip Code: ____________________ Marital Status: **M S W D Sep**

Insurance Name: ________________________

Member ID#: ________________________

Group #: ________________________

Telephone Number: ________________________

Emergency Contact

Name: _________________________________ Home Phone: __________________

Street Address: ____________________________ Mobile Phone: __________________

City: _______________________ State: _____ Relationship: __________________

Redlands Dental Surgery Center
Patient Health History

Patient Name: ______________________ Date of Birth: ________ Height: _______ Weight: ________

CIRCLE APPROPRIATE ANSWER (leave blank if unknown)

1. Yes No Is your general health good?
2. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If yes, please explain: ______________________
3. Yes No Are your being treated by a physician now?
   If yes, please explain: ______________________
4. Yes No Have you had any problems with prior dental treatment?
   If yes, please explain: ______________________
5. Yes No Are you in pain now?
   If yes, please explain: ______________________
6. Yes No Allergies to medications, food, latex?
   If yes, please list: ______________________

HAVE YOU EXPERIENCED:

7. Yes No Chest Pain (Angina)
8. Yes No Swollen Ankles
9. Yes No Shortness of breath
10. Yes No Recent weight loss, fever, night sweats
11. Yes No Persistent cough
12. Yes No Bleeding or bruising easily
13. Yes No Sinus problems
14. Yes No Difficulty swallowing
15. Yes No Frequent vomiting, nausea
16. Yes No Dizziness
17. Yes No Ringing in ears
18. Yes No Headaches
19. Yes No Fainting spells
20. Yes No Seizures
21. Yes No Jaundice
22. Yes No Joint pain/stiffness
23. Other ______________________

DO YOU OR HAVE YOU HAD:

24. Yes No Heart disease/defects
25. Yes No Heart attack
26. Yes No Heart murmur
27. Yes No Down Syndrome
28. Yes No Rheumatic Fever
29. Yes No Stroke
30. Yes No High blood pressure
31. Yes No Lung disease (COPD, emphysema, bronchitis)
32. Yes No Asthma
33. Yes No TB
34. Yes No Hepatitis, other liver disease
35. Yes No Stomach problems, ulcers
36. Yes No Diabetes
37. Yes No AIDS or HIV
38. Yes No Cancer, tumors
39. Yes No Arthritis / Osteoarthritis
40. Yes No Cerebral Palsy
41. Yes No Skin Disease
42. Yes No Eye Disease
43. Yes No Anemia
44. Yes No Herpes
45. Yes No Kidney Disease
46. Yes No Thyroid problem
47. Yes No Autism / ADHD
48. Yes No Intellectual Disability (mild / moderate / profound)

Medical conditions NOT listed on this form?
Please explain: ______________________

DO YOU OR HAVE YOU HAD:

49. Yes No Psychiatric care
50. Yes No Radiation treatment
51. Yes No Chemotherapy
52. Yes No Prosthetic heart valve
53. Yes No Artificial joints
54. Yes No Surgery ______________________
55. Yes No Hospitalization
56. Yes No Blood transfusion
57. Yes No Pacemaker
58. Yes No Contact lenses
59. Yes No Dialysis
60. Yes No VNS

ARE YOU TAKING:

61. Yes No Medications: List: ______________________
62. Yes No Biophosphate: Have you taken or are you taking?
63. Yes No Tobacco
64. Yes No Alcohol
65. Yes No Recreational Drugs: List: ______________________

WOMEN ONLY:

66. Yes No Are you/could you currently be pregnant
67. Yes No Are you taking birth control
71. Yes No Currently Breastfeeding

______________ ______________________ ______________________
Date Patient/Parent/Guardian Signature Doctor Signature

RECALL REVIEW:

______________ ______________________ ______________________
______________ ______________________ ______________________
______________ ______________________ ______________________
Date Patient/Parent/Guardian Signature Doctor Signature

This office screens patients for ATD's (aerosol transmissible disease) using health history forms and oral communication at the reception desk as patients enter our office. Any patient with suspected ATD is asked to go home and if emergency dental treatment necessary, is referred to a hospital. This office follows dental infection control requirements to help minimize the spread of ATD's.

ATD Screening Documentation- Patient Questionnaire

To ensure our patients are treated in an environment that promotes health and well-being, and in accordance with Cal/OSHA requirements for providing a safe and healthful workplace, patients suffering from ATD such as mumps, chickenpox, measles, influenza, tuberculosis or other illnesses that may be spread by airborne transmission should notify our office immediately.

Respiratory Hygiene and Cough Etiquette

During your time in our facility, please abide by the following practices recommended by the Centers for Disease Control and Prevention.

- Cover your nose and/or mouth when coughing or sneezing.
- Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use.
- Wash your hands with soap and water or with alcohol-based hand sanitizer after you have had contact with potentially contaminated respiratory secretions.

Patient Information

Patient's Name: ______________________________

Signature/Parent/Guardian Signature: ______________________________ Date: __________

Are you suffering from any of the following signs or symptoms of aerosol transmissible illness?

Please mark (YES) or (NO) for each question:	**YES**	**NO**
1. Do you currently have a contagious respiratory illness?	___	___
2. Have you had a cough for at least 4 weeks not explained by noninfectious conditions?	___	___
3. Have you had coughing fits that interfere with eating, drinking, talking or breathing?	___	___
4. In addition to cough, are currently experiencing, or experienced recently:		
• Fever	___	___
• Chronic Fatigue	___	___
• Cough up blood	___	___
• Painful, swollen salivary glands	___	___
• Unexplained rash	___	___

5. Do you have or have you been exposed to anyone with an infectious aerosol transmissible other than seasonal influenza? (See below for a list of such illnesses and circle specific diseases exposures.)

- Flu (other than seasonal)
- Chickenpox
- Smallpox
- Tuberculosis
- Diphtheria
- Meningitis
- Mumps
- Pneumonia
- Parvovirus
- Epstein-Barr Virus
- Strep
- Whooping Cough
- Shingles
- Measles
- MRSA
- SARS
- Scarlet Fever
- Other infections: ________

Redlands Dental Surgery Center

NON-CONTRACTED HEALTH INSURANCE POLICY

Redlands Dental Surgery Center is an outpatient surgery center which specializes in general dentistry. Because of this, our facility bills both health and dental insurance plans.

Our office is a non-contracted facility with the following insurances:

Kaiser
Health Net
LA CARE
Caloptima
All HMO plans

Because these insurances DO NOT carry contracts with our facility, there is an outpatient fee of $500.00 due at each anesthesia appointment. You do have the option to find a contracted provider within your plans network to avoid this fee.

By signing below, I am acknowledging that I am aware of the out-patient facility fee of $500.00 and responsible for this charge if I have Kaiser, Health Net, LA Care, Caloptima, or any of the HMO plans.

____
Print Name

____
Signature

____
Date

CONSENT TO BILL INSURANCE PLAN

Redlands Dental Surgery Center
1180 Nevada Street, Suite 100
Redlands, CA 92374
(909) 335-0474 or Fax (909) 335-0477

Patient Name: ______________________________________ Date of Birth ____________

Consent to bill insurance plan(s):

I give permission for Redlands Dental Surgery Center to bill my insurance company(ies) for covered services and to exchange information necessary to secure payment for these services. Such necessary information may include patient name, diagnosis, service dates, types of services, and other pertinent information needed to process claims. I understand that I am responsible to pay any balances not covered by my insurance plan. I also understand that if an insurance payment is made directly to me for services rendered at Redlands Dental Surgery Center, I am responsible for immediately forwarding such payments to Redlands Dental Surgery Center, who rendered the service. I will notify Redlands Dental Surgery Center of any changes to the above name patient's dental insurance, health insurance and/or Medi-Cal/Denti-Cal coverage including denial information.

______________________	______________________	____________
Signature	Relationship	Date

Redlands Dental Surgery Center
Acknowledgement of Receipt of Forms

Patient Name:______________________________ Date of Birth: __________

Attached to this form you will find a copy of your List of Patient Rights, Privacy Policy / HIPAA (Health Insurance Portability & Accountability Act), Dental Materials Fact Sheet, Cancellation Policy, and information regarding Advance Directives. Please detach form and read carefully; this is yours to keep.

I have received a copy and understand the *List of Patient Rights*.

____
Initial

I have received a copy and understand the *Privacy Policy / HIPAA*.

____
Initial

I have received a copy and understand the *Dental Materials Fact Sheet*.

____
Initial

I have received a copy and understand the *Cancellation Policy*.

____
Initial

I have an Advance Directive (Yes / No) – **PLEASE CIRCLE**

I hereby acknowledge that I have received a copy of how to obtain an Advance Directive. I am aware Redlands Dental Surgery Center does **NOT** honor Advance Directives.

____
Initial

______________________	______________________	__________
Signature	Relationship	Date

LIST OF PATIENT RIGHTS

IN ACCORDANCE WITH HEALTH AND SAFETY CODES, THE SURGERY CENTER AND MEDICAL STAFF HAVE ADOPTED THE FOLLOWING LIST OF PATIENT RIGHTS:

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting: You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification: In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Redlands Dental Surgery Center
Telephone: (909)335-0474 Fax: (909)912-8800
Address: 1180 Nevada Street Suite 100, Redlands CA 92374

Or Contact: Department of Public Health: (800) 383-4777

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

ADVANCE DIRECTIVE

We do not honor Advance Directives which means we will always use life saving measures in an emergency. Advance Directives are instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity. A living will is one form of an advance directive, leaving instructions for treatment. If you would like more information on how to obtain an Advance Directive you may call (800) 510-2020 or (916)322-3887. You may also contact California Department of Aging 1600 "K" Street, Sacramento CA, 96814.

Dental Board of California Dental Materials Fact Sheet

The following document is the Dental Board of California's Dental Material Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Materials Fact Sheet; and its linkage to the DCA Web site does not constitute an endorsement of the content of this document.

Adopted by the Board on October 17, 2001

Required by Chapter 801 Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome(base-metal) alloys. Each material has its own advantages and disadvantage, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." "A Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published between 1993-2004. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made.

The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary material used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Please ask if you would like a copy of the full Dental Materials Fact Sheet.

Cancellation Policy

Redlands Dental Surgery Center requires a two-business day (48 hour) advance notice for any changes or cancellations of your surgery appointment. This allows us time to fill the appointment we initially reserve for you by another patient who may be waiting for a surgery appointment. We do, however, understand that illness and emergencies do occur and will accommodate for those rare instances.

A fee of $25 will be charged for failure to notify our office within the allotted time. We appreciate your promptness in regards to this matter.

Privacy Policy / HIPAA (Health Insurance Portability & Accountability Act)

This Notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect September 23, 2013 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. For more information about our privacy practices or additional copies of this Notice, please contact us (contact information below).

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment: We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment: We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Family & Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email: We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health Related Services: We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership: If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health: We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet & Announcement: Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

THIS CENTER IS OWNED AND OPERATED BY RUSSELL O. SEHEULT DDS, A.P.C.