Bay Park Dental Group
Tessa L. Miller, D.D.S. & Associates
2619 Clairemont Drive
San Diego, CA 92117

Dear Patient,

Welcome to our practice, **Bay Park Dental Group**. We are pleased you have chosen us to provide your dental care and look forward to getting to know you.

Please take a few moments to familiarize yourself with our office policy and complete the following forms.

Office Policy

We invite our patients to arrive early to their appointments and enjoy complimentary refreshments, periodicals, and television while they wait in our reception area. Please notify us right away if you are running late or having difficulty finding parking. Our patients are always welcome to park in the church parking lot and shopping center lot behind our building. Please be aware that if you are more than a few minutes late, it may be necessary to reschedule your appointment depending on the length of the original appointment.

If you are taking any medication, please bring an accurate and updated list of their names with you to your appointment. If you need pre-medication prior to dental procedures, please bring proper medical documentation for the pre-medication.

Payment Policy

A treatment plan with the estimated costs (patient copayment) will always be presented to you prior to the start of treatment. Please keep in mind the estimated costs are an **estimate** and may be subject to change. As a courtesy to you, we will bill your insurance for their portion while your **estimated share (copay) is due at the time of service.**

Please feel free to always ask questions. You are important to us and we want you to be informed about your dental health. We look forward to getting to know you!

Sincerely,
Tessa Miller D.D.S. and Associates

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Patient and/or Insured Authorization for "Signature on File"
(Release of information/financial responsibility/ authorization for payment)

Please read the following policy carefully and sign at the bottom of the page.

I _____, hereby authorize the office of Dr. Tessa Miller and Associates, a Professional Dental Corporation, to affix my name to any and all claims or documents related to any and all health benefits due to me.

I hereby authorize payment of dental benefits, otherwise payable to me, directly to the dental office of Dr. Tessa Miller. I agree to be responsible for all charges for dental services not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize the release of any information (including x rays, charting, and chart notes) related to a claim so that payment may be remitted to the office of Dr. Tessa Miller.

- As a patient with insurance benefits, you are responsible for payment for all services rendered according to the list of surcharges set by your dental insurance. Fees for services are paid at the time the services are rendered.
- Although fees are given with every treatment plan, they are subject to change at any time for any such reasons: changes in treatment plan due to unexpected circumstances, insurance underpayments on elective treatments or upgrades, or outright denial of claims. Under the above circumstances and also those that may not be listed here, you will be responsible for any remaining balance and are expected to pay-in-full.

_____
Initial

I understand that as a contracted provider, Dr. Tessa Miller is not allowed to provide insurance fees to any patient not covered under that insurance.

Cancellation Policy

As we have set aside your appointment time specifically for you and do not double book patients, **please give us at least a 2 business day notice if you need to reschedule or cancel your appointment. Failure to provide adequate notice may result in a charge of $50/hour to your account or the requirement of a fully refundable deposit for the next appointment.** This charge is to be paid before any future appointments are made and prior to continuing treatment unless otherwise agreed with Dr. Tessa Miller and/or her staff.

_____ _____
Signature of Patient or Guardian Date

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Patient Information

Legal Name:_____ Birth date:_____ - _____ - _____

Prefer to be called:_____ Title (circle): **Mr. Mrs. Ms. Dr.**

Home Address: _____ City: _____ Zip code:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Occupation:_____ Employer:_____ Work Phone:_____

Social Security #_____ - _____ - _____ Marital Status (circle): **S M W D**

Dental Insurance? Yes____ No____ Insurance Company:_____ Policy #:_____

Subscriber's Name:_____ Employer:_____

Subscriber's SSN:_____-_____-_____ Subscriber's Birth date:_____ - _____ - _____

Member ID:_____ Insurance Company Phone Number:_____

Financially Responsible Person:_____

Responsible Person's address (if different from above):_____

_____

Review of Chief Concern

- Why are you seeking dental care at this time?_____
- Description of chief concern (onset, duration, intensity, frequency, etc.):_____
- Do you have discomfort to any of the following? Hot:_____ Cold:_____ Sweets:_____ Chewing:_____

Areas you would like more information on:

❑ Prosthodontics	❑ Dentures
❑ Implants	❑ Whitening
❑ Veneers	❑ Orthodontics
❑ Gum Disease	❑ Oral Surgery
❑ Desentizing Procedures	

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Dental History

Former Dentist:_____ City:_____ Phone Number:_____

Date of last visit:_____ Services rendered:_____

Date of last X rays:_____ Last cleaning:_____

How often do you have your teeth professionally cleaned?_____

How often do you brush?_____/day **floss:_____/week**

Do you use fluoride toothpaste?_____ **Mouthwash/rinse?_____**

Do your gums bleed while brushing/flossing? _____

Medical History

Physician's name:_____ Phone:_____

Are you receiving any treatment for a medical condition? (circle) Yes No

If yes, what conditions?_____

Have you been hospitalized or had a serious illness within the past **5** years? (circle) Yes No

Please list any medications you are actively taking (including over-the counter, vitamins, supplements):_____

_____

Are you allergic to any of the following:

- ❑ Penicillin
- ❑ Amoxicillin
- ❑ Codeine
- ❑ Local injected anesthetics
- ❑ Latex
- ❑ Ibuprofen
- ❑ Other:_____

Do you smoke? (circle) Yes No How much per day?_____ # of years?_____

Do you drink? (circle) Yes No How much per day?_____

Are you using any recreational drugs? (circle) Yes No, If YES please list: _____

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Please check any of the following which you have or had in the past:

❑ Heart Disease/Attack	❑ Asthma	❑ Hepatitis A
❑ Heart failure	❑ Hay Fever	❑ Hepatitis B
❑ Angina/Chest Pain	❑ Sinus Problems	❑ Hepatitis C
❑ High Blood Pressure	❑ Allergies/Hives	❑ Liver Disease
❑ Heart Murmur	❑ Diabetes	❑ Jaundice
❑ Mitral Valve Prolapse	❑ Thyroid Disease	❑ Blood Transfusion
❑ Rheumatic Fever	❑ X-ray or Cobalt Treatment	❑ Drug/Alcohol Addiction
❑ Congenital Heart Disease	❑ Chemotherapy	❑ HIV/AIDS
❑ Scarlet Fever	❑ Cancer/Radiation Treatment	❑ Hemophilia
❑ Artificial Heart Valve	❑ Arthritis	❑ Venereal Disease
❑ Pacemaker	❑ Rheumatism	❑ Cold Sores
❑ Heart Surgery	❑ Lupus	❑ Epilepsy
❑ Stroke	❑ Steroid Medicine	❑ Fainting/Dizziness
❑ Kidney Problems	❑ Glaucoma	❑ Nervousness
❑ Ulcers	❑ Pain in jaw joints	❑ Psychiatric Treatment
❑ Emphysema	❑ Artificial Joints	❑ Sickle Cell Disease
❑ Cough		❑ Bruise/Bleed Easily
❑ Tuberculosis		❑ Anemia

Women: Are you/do you suspect you are pregnant? (circle) Yes No
Are you nursing? (circle) Yes No

Consent (please initial each paragraph and sign at the bottom of the page)

_____ I authorize the doctor and dental assistant to take x-rays, impressions, photographs, or any other diagnostic aids to make a thorough dental diagnosis. These diagnostic aids will be used to formulate treatment plans, may be shared with other doctors, dental laboratories, or my dental insurance.

_____ I will then authorize doctor to perform dental treatment, administer medication, and therapy as explained to me in advance.

_____ I understand there are possible risks and complications associated with the administration of local anesthetics and drugs (such as swelling, bleeding, pain, nausea, bruising, tingling, allergic reactions, hematoma (swelling or bleeding the near injection site), fainting, coma, or death).

_____ I understand that responsibility for payment for dental services provided in this office for myself or my dependants is mine, due, and payable at the time services are rendered.

Signature_____ Relationship to patient:_____ Date: _____

Last Name **First Name** **MI**

Patient record#: _____

Date of Birth: ____/_____/_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I am acknowledging that:

I am either the patient or the patient's personal representative;
I have received a copy of the "Notice of Privacy Practices" for _____ County/District Health Department; and
I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____ _____
Signature of patient or parent/legal guardian/legally responsible person Date

_____
Description of relationship to patient

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions

Part 1. Complete if signature requested but not obtained:
Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

D Patient/personal representative refused to sign form

D Other _____

_____

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:

D Form mailed/sent to patient/personal representative on _____.
Date

Part 3. Complete if either Part 1 or Part 2 completed:

_____ _____
Signature of staff member Date

Last Name **First Name** **MI**

Patient record#: _____

Date of Birth: ____/_____/_____

AVISO DE PROCEDIMIENTOS DE PRIVACIDAD

Firmando abajo, estoy reconociendo eso:

Soy del paciente el representante personal paciente o;

He recibido una copia del aviso de procedimientos de privacidad para _____ Departamento de la salud del condado/del districto; y

Entiendo que puedo entrar en contacto con a la persona nombrada en el aviso si tengo preguntas sobre el contenido del aviso.

_____ _____

Firma del paciente o del padre/del guarda legal/de la persona legalmente responsable Fecha

_____

Descripción de la relación al paciente

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions

Part 1. Complete if signature requested but not obtained:

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

D Patient/personal representative refused to sign form

D Other _____

_____

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:

D Form mailed/sent to patient/personal representative on _____.
Date

Part 3. Complete if either Part 1 or Part 2 completed:

_____ _____

Signature of staff member Date

INSTRUCTIONS ACKNOWLEDGMENT FORM

Purpose of the Form

Under the HIPAA Privacy Rule, the local health department is required to disseminate its Notice of Privacy Practices to all patients upon the first delivery of service after April 14, 2003, and to make a good faith effort to obtain the patient's acknowledgment that he or she has received the Notice. If the acknowledgment cannot be obtained, the department must document that it attempted to obtain the acknowledgment and the reason it was unable to do so.[1] This Acknowledgment Form serves two purposes:

Top portion: The signature of the patient (or the patient's personal representative) on the top portion of the form documents the acknowledgment of receipt of the Notice of Privacy Practices.

Bottom portion: If the signature of the patient or personal representative is not obtained on the top portion of the form, the bottom portion provides a place for the staff member to document his or her good faith effort to obtain the acknowledgment.

Instructions for Staff

Step One: Provide the Notice of Privacy Practices to patients receiving services for the first time since April 14, 2003.

a. In most cases, you will be able to give the Notice directly to the patient or the patient's personal representative (such as a parent or guardian). If you are able to do this, proceed to Step Two, below.

b. In some cases, you will not be able to give the Notice directly to the patient or personal representative. For example, a patient with a personal representative may be presented for care by someone other than the personal representative or you may provide care to someone for the first time over the telephone. In such cases, you should mail the Notice to the patient or the patient's personal representative, or ask the person who presents the patient for care to deliver the Notice to the personal representative. If you must do this, skip Step Two and go directly to Step Three, below.

Step Two: If the patient or personal representative is available, complete the name, patient record number, and DOB portions of an Acknowledgment Form, then ask the patient or personal representative to sign and date the top portion (above the bold line) of the form.

a. If you obtain the signature, file the form *[health department may choose to specify where the form is to be filed]*. You do not need to complete the bottom portion of the form. This completes the process. You do not need to complete Steps Three and Four below.

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[1] Section 164.520 of the HIPAA Privacy Rule (45 C.F.R. § 164.520).

b. If you do not obtain the signature, complete Parts 1 and 3 in the bottom portion of the form. File the form. This completes the process. You do not need to complete Steps Three and Four below.

Step Three: If the patient or the patient's personal representative is not available to sign the Acknowledgment Form, complete the name, patient record number, and DOB portions of *two separate* Acknowledgment Forms and do all of the following:

a. First Acknowledgment Form: Mail or send the first Acknowledgment Form to the patient or personal representative along with the Notice of Privacy Practices, and ask the patient or personal representative to sign and return the form.

> Example: An adult aunt of a child brings the child to the health department for immunizations. The aunt has been authorized by the child's parent to obtain the immunizations, but the aunt is not the child's personal representative. The parent is the personal representative. You must send the Notice and an Acknowledgment Form to the parent. Either mail both items to the parent, or give them to the aunt and ask her to deliver them to the parent, along with the request that the parent sign and return the form.
>
> Example: An adult patient contacts the health department for the first time by phone and receives health care over the phone. You must send the Notice and an Acknowledgment Form to the patient, along with the request that he or she sign and return the form.

b. Second Acknowledgment Form: Complete Parts 2 and 3 of the bottom portion of the second Acknowledgment Form and file it. Go to Step Four.

Step Four: The final step depends upon whether the patient or personal representative signs the Acknowledgment Form and returns it:

a. If the personal representative signs and returns the form, file the signed form and discard the second form that was previously filed under Step Three, part b, above.

b. If the personal representative does not sign and return the form, leave the second Acknowledgment Form in the file. It is understood that this second form demonstrates that you made a "good faith effort" to obtain an acknowledgment, as required by the HIPAA Privacy Rule. *[Note: The health department could elect to have additional policies and procedures in place to follow up on outstanding signatures, but such additional steps are not necessarily required]*.