DOUGLAS DENTAL
& ORTHODONTICS
elevate your smile

Contact & Insurance Information

Patient Name: _____ (Last) _____ (First) _____ (Nickname) Age: _____

Patient DOB: _____ Patient Phone #: _____

Mailing/Billing Address:

_____
Street Address City State Zip

Patient Email: _____
*used for appointment reminders and coorespondence

How did you find us: _____ Referred by: _____

Emergency Contact: _____ (Name) Relation: _____ Phone: _____

Primary Insurance Holder: _____ or ☐ No Insurance
(Subscriber) First Last

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Subscriber DOB: _____

Insurance Carrier: _____ Ins. Carrier Phone #: _____

Member ID or SSN of Subscriber: _____

Group Name: _____ Group Number: _____

☐ I, as the patient, have secondary dental coverage

2nd Insurance: _____ Ins. Phone #: _____

Subscriber Name: _____ Subscriber DOB: _____

Member ID or SSN: _____

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Individual filling out form if not self: _____ (Name) Relation to pt: _____

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MEDICAL HISTORY

Patient Name: (Last) _____ (First) _____ Date of Birth: _____

Name of Physician/and their specialty: _____

Most recent physical examination: _____

Purpose: _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other: _____		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. orthopedic implant (joint replacement)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10 a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12 prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13 emphysema, shortness of breath, sarcoidosis	☐	☐
14 tuberculosis, measles, chicken pox	☐	☐
15 asthma	☐	☐
16 breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17 kidney disease	☐	☐
18 liver disease	☐	☐
19 jaundice	☐	☐
20 thyroid, parathyroid disease, or calcium deficiency	☐	☐
21 hormone deficiency	☐	☐
22 high cholesterol or taking statin drugs	☐	☐

.

23	diabetes (HbA1c = _____)	☐	☐
24	stomach or duodenal ulcer	☐	☐
25	digestive disorders (i.e. celiac disease, gastric reflux)	☐	☐
26	osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27	arthritis	☐	☐
28	autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29	glaucoma	☐	☐
30	contact lenses	☐	☐
31	head or neck injuries	☐	☐
32	epilepsy, convulsions (seizures)	☐	☐
33	neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34	viral infections and cold sores	☐	☐
35	any lumps or swelling in the mouth	☐	☐
36	hives, skin rash, hay fever	☐	☐
37	STI/STD/HPV	☐	☐
38	hepatitis (type _____)	☐	☐
39	HIV/AIDS	☐	☐
40	tumor, abnormal growth	☐	☐
41	radiation therapy	☐	☐
42	chemotherapy, immunosuppressive medication	☐	☐
43	emotional difficulties	☐	☐
44	psychiatric treatment	☐	☐
45	antidepressant medication	☐	☐
46	alcohol/recreational drug use	☐	☐

ARE YOU:		YES	NO
47	presently being treated for any other illness	☐	☐
48	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐	☐
49	taking medication for weight management	☐	☐
50	taking dietary supplements	☐	☐
51	often exhausted or fatigued	☐	☐
52	experiencing frequent headaches	☐	☐
53	a smoker, smoked previously or use smokeless tobacco	☐	☐
54	considered a touchy/sensitive person	☐	☐
55	often unhappy or depressed	☐	☐
56	FEMALE - taking birth control pills	☐	☐
57	FEMALE - currently pregnant	☐	☐
58	MALE - prostate disorders	☐	☐

IF YOU MARKED YES TO ANY OF THE ABOVE, PLEASE USE THIS SPACE FOR ADDITIONAL DETAILS:

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

DRUG:	PURPOSE:

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient/Guardian Signature

Date

Doctor Signature

DOUGLAS DENTAL & ORTHODONTICS
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DENTAL HISTORY

Patient Name: (Last) _____ (First) _____ Date of Birth: _____

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist: _____ How long have you been a patient? _____

Date of most recent dental exam: _____ Date of most recent x-rays: _____

Date of most recent treatment (other than a cleaning): _____

I routinely see my dentist every: ☐ 3 Months ☐ 4 Months ☐ 6 Months ☐ 12 Months ☐ Not Routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning sensation in your mouth?	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐

BITE AND JAW JOINT	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	☐	☐

25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or rest your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench your teeth in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐

SMILE CHARACTERISTICS

	YES	NO
33. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

IF YOU MARKED YES TO ANY OF THE ABOVE, PLEASE USE THIS SPACE FOR ADDITIONAL DETAILS:

Patient/Guardian Signature

Date

Doctor Signature

DOUGLAS DENTAL
& ORTHODONTICS
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Missed Appointment and Cancellation Policy

Our goal is to provide quality dental care in a timely manner. Missed appointments and cancellations without **TWO BUSINESS DAYS** notice, impacts our ability to provide dental care to you and limits the availability of appointments for other patients who could have been scheduled.

If you are unable to keep your appointment, please notify the office with at least **TWO BUSINESS DAYS** notice to reschedule your appointment. Patients who miss their reserved appointments or who cancel without **TWO BUSINESS DAYS** notice will be charged a missed appointment fee of **$50.00 PER HOUR RESERVED**, which must be paid prior to their next appointment.

We understand there are emergencies and unforeseen circumstances that cause last minute cancellations or missed appointments, in which case the fee may be waived at our discretion. Multiple missed or cancelled appointments may result in the termination of the patient from our practice.

For those of you who find it difficult to keep an appointment due to a busy or constantly changing schedule, our office has a suggestion that has worked for many of our other patients. Instead of scheduling an appointment that you might not be able to keep, call the office on a day you are available and the staff will try to find you an appointment that day if the schedule allows.

I have read the above policy and agree to all of the terms and understand that if I violate this policy it may result in the termination of my doctor/patient relationship.

Signature:_____ Date: _____

Print Name: _____ DOB:_____

DOUGLAS DENTAL
& ORTHODONTICS
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Regulatory Compliance

Notice of Privacy Practices

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 January 1, 2010 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 health care operations.
For example:

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 health care 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 to 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.

Health Care Operations
We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care 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 health care operations, you may give us electronic, written or verbal 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.

To Your Family and 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 may 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 your 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 health care. 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 your 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

Notice of Privacy Practices (continued)

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

Sign-In Sheet and 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.

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, health care 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.

Notice of Privacy Practices (continued)

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.

Research
Your health information may be disclosed to researchers for research purposes. In this situation, written authorization is not required as approved by an Institutional Review Board or privacy board.

Fundraising
We may use or disclose demographic information and dates of treatment in order to contact you for fundraising activities. If you no longer wish to receive these communications, notify us at the contact information provided below and we will stop sending further fundraising information.

Patient Rights (continued)

Questions and Complaints

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

Contact: Douglas Dental & Orthodontics

Telephone: 916-783-4888 Fax:

Email: office@douglas.dental

Address: 2424 Professional Drive. Roseville, CA 95661

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.

Douglas Dental & Orthodontics complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. *You May Refuse to Sign This Acknowledgement*

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____ [full name], have received a copy of the Douglas Dental & Orthodontics Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program Use Only

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)

DOUGLAS DENTAL
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DoseSpot eRx Medical History & Consent Form

First Name: _____

Last Name: _____

DOB: _____

Effective January 1st, 2022: all prescribing providers are required, by law to send patient prescriptions electronically for all medications.

I allow DoseSpot eRx third party access to my medical prescription(s) history. This history will be reflected & communicated with my preferred pharmacy.

Signature _____

DOUGLAS DENTAL
& ORTHODONTICS
elevate your smile

Contact & Insurance Information

Patient Name: _____ (Last) _____ (First) _____ (Nickname) Age: _____

Patient DOB: _____ Patient Phone #: _____

Mailing/Billing Address:

_____
Street Address City State Zip

Patient Email: _____
*used for appointment reminders and coorespondence

How did you find us: _____ Referred by: _____

Emergency Contact: _____ (Name) Relation: _____ Phone: _____

Primary Insurance Holder: _____ or ☐ No Insurance
(Subscriber) First Last

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Subscriber DOB: _____

Insurance Carrier: _____ Ins. Carrier Phone #: _____

Member ID or SSN of Subscriber: _____

Group Name: _____ Group Number: _____

☐ I, as the patient, have secondary dental coverage

2nd Insurance: _____ Ins. Phone #: _____

Subscriber Name: _____ Subscriber DOB: _____

Member ID or SSN: _____

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Individual filling out form if not self: _____ (Name) Relation to pt: _____

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MEDICAL HISTORY

Patient Name: (Last) _____ (First) _____ Date of Birth: _____

Name of Physician/and their specialty: _____

Most recent physical examination: _____

Purpose: _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other: _____		
3. heart problems, or cardiac stent within the last six months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. orthopedic implant (joint replacement)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10 a stroke (taking blood thinners)	☐	☐
11. anemia or other blood disorder	☐	☐
12 prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13 emphysema, shortness of breath, sarcoidosis	☐	☐
14 tuberculosis, measles, chicken pox	☐	☐
15 asthma	☐	☐
16 breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17 kidney disease	☐	☐
18 liver disease	☐	☐
19 jaundice	☐	☐
20 thyroid, parathyroid disease, or calcium deficiency	☐	☐
21 hormone deficiency	☐	☐
22 high cholesterol or taking statin drugs	☐	☐

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23	diabetes (HbA1c = _____)	☐	☐
24	stomach or duodenal ulcer	☐	☐
25	digestive disorders (i.e. celiac disease, gastric reflux)	☐	☐
26	osteoporosis/osteopenia (i.e. taking bisphosphonates)	☐	☐
27	arthritis	☐	☐
28	autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29	glaucoma	☐	☐
30	contact lenses	☐	☐
31	head or neck injuries	☐	☐
32	epilepsy, convulsions (seizures)	☐	☐
33	neurologic disorders (ADD/ADHD, prion disease)	☐	☐
34	viral infections and cold sores	☐	☐
35	any lumps or swelling in the mouth	☐	☐
36	hives, skin rash, hay fever	☐	☐
37	STI/STD/HPV	☐	☐
38	hepatitis (type _____)	☐	☐
39	HIV/AIDS	☐	☐
40	tumor, abnormal growth	☐	☐
41	radiation therapy	☐	☐
42	chemotherapy, immunosuppressive medication	☐	☐
43	emotional difficulties	☐	☐
44	psychiatric treatment	☐	☐
45	antidepressant medication	☐	☐
46	alcohol/recreational drug use	☐	☐

ARE YOU:		YES	NO
47	presently being treated for any other illness	☐	☐
48	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)	☐	☐
49	taking medication for weight management	☐	☐
50	taking dietary supplements	☐	☐
51	often exhausted or fatigued	☐	☐
52	experiencing frequent headaches	☐	☐
53	a smoker, smoked previously or use smokeless tobacco	☐	☐
54	considered a touchy/sensitive person	☐	☐
55	often unhappy or depressed	☐	☐
56	FEMALE - taking birth control pills	☐	☐
57	FEMALE - currently pregnant	☐	☐
58	MALE - prostate disorders	☐	☐

IF YOU MARKED YES TO ANY OF THE ABOVE, PLEASE USE THIS SPACE FOR ADDITIONAL DETAILS:

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

DRUG:	PURPOSE:

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient/Guardian Signature

Date

Doctor Signature

DOUGLAS DENTAL & ORTHODONTICS
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PEDIATRIC DENTAL HISTORY
Age 16 and Under

Patient Name: (Last) _____ (First) _____ Date of Birth: _____

SOCIAL HISTORY

	YES	NO
1. Has patient seen a dentist yet?	☐	☐
2. Date of last dental visit: _____		
3. Reason for leaving previous office: _____		
4. Has patient had any fillings/crowns/extractions previously?	☐	☐
5. Has patient had any negative experiences at a previous dental office?	☐	☐
6. Family health/dental issues?	☐	☐
7. Is patient nervous about dental treatment?	☐	☐
8. Has patient had sealants placed?	☐	☐
9. Did previous office place silver diamine fluoride (SDF) on patient?	☐	☐

HYGIENE HISTORY

	YES	NO
10 Brushing frequency and duration: _____		
11. Flossing frequency and duration: _____		
12 Who brushes and flosses for patient? _____		
13 Is brushing or flossing supervised?	☐	☐
14 How much toothpaste do you use? _____		
15 When is brushing done? _____		

FLUORIDE HISTORY

	YES	NO
16 Lives in a fluoridated community?	☐	☐
17 Drinks tap water?	☐	☐
18 Uses a fluoridated toothpaste?	☐	☐

DIET: **What is common for the following meals both eating and drinking?**

19 Breakfast: _____
20 Lunch: _____
21 Dinner: _____
22 Snacks: _____

DOES THE PATIENT HAVE ANY OF THE FOLLOWING HABITS?

	YES	NO
23 Pacifier use	☐	☐
24 Thumb sucking	☐	☐
25 Pressing tongue against front teeth	☐	☐
26 Mouth breathing	☐	☐

SLEEPING

	YES	NO
27 Does the child have any problems sleeping?	☐	☐
28 Does the child snore?	☐	☐
29 Have tonsils been checked by pediatrician?	☐	☐
30 Have tonsils been removed?	☐	☐

DOUGLAS DENTAL
& ORTHODONTICS
elevate your smile

Missed Appointment and Cancellation Policy

Our goal is to provide quality dental care in a timely manner. Missed appointments and cancellations without **TWO BUSINESS DAYS** notice, impacts our ability to provide dental care to you and limits the availability of appointments for other patients who could have been scheduled.

If you are unable to keep your appointment, please notify the office with at least **TWO BUSINESS DAYS** notice to reschedule your appointment. Patients who miss their reserved appointments or who cancel without **TWO BUSINESS DAYS** notice will be charged a missed appointment fee of **$50.00 PER HOUR RESERVED**, which must be paid prior to their next appointment.

We understand there are emergencies and unforeseen circumstances that cause last minute cancellations or missed appointments, in which case the fee may be waived at our discretion. Multiple missed or cancelled appointments may result in the termination of the patient from our practice.

For those of you who find it difficult to keep an appointment due to a busy or constantly changing schedule, our office has a suggestion that has worked for many of our other patients. Instead of scheduling an appointment that you might not be able to keep, call the office on a day you are available and the staff will try to find you an appointment that day if the schedule allows.

I have read the above policy and agree to all of the terms and understand that if I violate this policy it may result in the termination of my doctor/patient relationship.

Signature:_____ Date: _____

Print Name: _____ DOB:_____

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Regulatory Compliance

Notice of Privacy Practices

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 January 1, 2010 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 health care operations.
For example:

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 health care 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 to 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.

Health Care Operations
We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care 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 health care operations, you may give us electronic, written or verbal 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.

To Your Family and 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 may 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 your 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 health care. 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 your 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

Notice of Privacy Practices (continued)

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

Sign-In Sheet and 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.

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, health care 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.

Notice of Privacy Practices (continued)

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.

Research
Your health information may be disclosed to researchers for research purposes. In this situation, written authorization is not required as approved by an Institutional Review Board or privacy board.

Fundraising
We may use or disclose demographic information and dates of treatment in order to contact you for fundraising activities. If you no longer wish to receive these communications, notify us at the contact information provided below and we will stop sending further fundraising information.

Patient Rights (continued)

Questions and Complaints

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

Contact: Douglas Dental & Orthodontics

Telephone: 916-783-4888 Fax:

Email: office@douglas.dental

Address: 2424 Professional Drive. Roseville, CA 95661

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.

Douglas Dental & Orthodontics complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. *You May Refuse to Sign This Acknowledgement*

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____ [full name], have received a copy of the Douglas Dental & Orthodontics Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program Use Only

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)

DOUGLAS DENTAL
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DoseSpot eRx Medical History & Consent Form

First Name: _____

Last Name: _____

DOB: _____

Effective January 1st, 2022: all prescribing providers are required, by law to send patient prescriptions electronically for all medications.

I allow DoseSpot eRx third party access to my medical prescription(s) history. This history will be reflected & communicated with my preferred pharmacy.

Signature _____