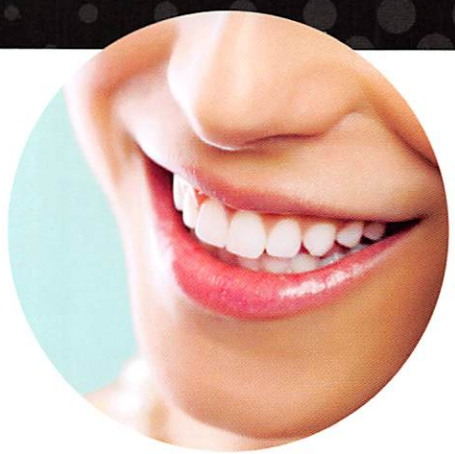
HEALTHY MOUTH BASELINE



A healthy body starts with a healthy mouth.

Recent research has shown that heart disease, cancer, diabetes, pregnancy and breathing problems are complicated by infection in the mouth. As a member of your health care team, we will check for the following risks to your overall health to determine your Healthy Mouth Baseline.

SOFT TISSUES
(Cheeks, Tongue, Palate, etc.)

- ○ LUMPS/BUMPS
- ○ SORES
- ○ DISCOLORATIONS

TEETH

- ○ LOOSE TEETH
- ○ MISSING TEETH
- ○ CRACKED/BROKEN TEETH
- ○ LARGE SPACES
- ○ EXCESSIVE WEAR
- ○ SENSITIVITY
- ○ FOOD TRAPS
- ○ BROKEN FILLINGS
- ○ CAVITIES

FACE

- ○ FREQUENT HEADACHES
- ○ CLENCHING/GRINDING
- ○ CLICKING/POPPING JAW
- ○ PAIN

GUMS

- ○ BLEEDING
- ○ BAD ODOR/TASTE
- ○ DEEP POCKETS
- ○ PLAQUE/TARTAR
- ○ RECESSION
- ○ SWELLING

HABITS

- ○ SMOKING
- ○ SLEEP DISORDER
- ○ SNORING
- ○ BAD BREATH
- ○ DRY MOUTH
- ○ MEDICATIONS

ACTION ITEMS:

- ○ Begin/complete periodontal treatment
- ○ See restorative dentist for possible treatment
- ○ Refer to secondary dental specialist _____
- ○ Seek medical doctor consultation
- ○ Other _____

UENO CENTER
Dental Specialists
PERIODONTICS • IMPLANTOLOGY
2160 S. Bascom Ave.,# 1 Campbell, CA 95008
p (408) 371-7616 f (408) 371-7651 Website: Ueno.Center

THE MOUTH-BODY CONNECTION
(THE ORAL-SYSTEMIC LINK)

A healthy mouth protects your brain, heart and general health.

ALZHEIMER'S DISEASE & DEMENTIA

Oral bacteria has been linked to accelerating brain shrinkage, a leading factor in Alzheimer's Disease and Dementia.
– Frontiers in Aging Neuroscience, 2017

DRY MOUTH

Many medications taken can lead to dry mouth, which significantly elevates risk for gum disease and tooth decay.
– WebMD, 2017

LUNG DISEASE

Oral bacteria that gets aspirated into the lungs has been shown to cause pneumonia and lung disease complications.
– National Institutes of Health, 2016

OBESITY

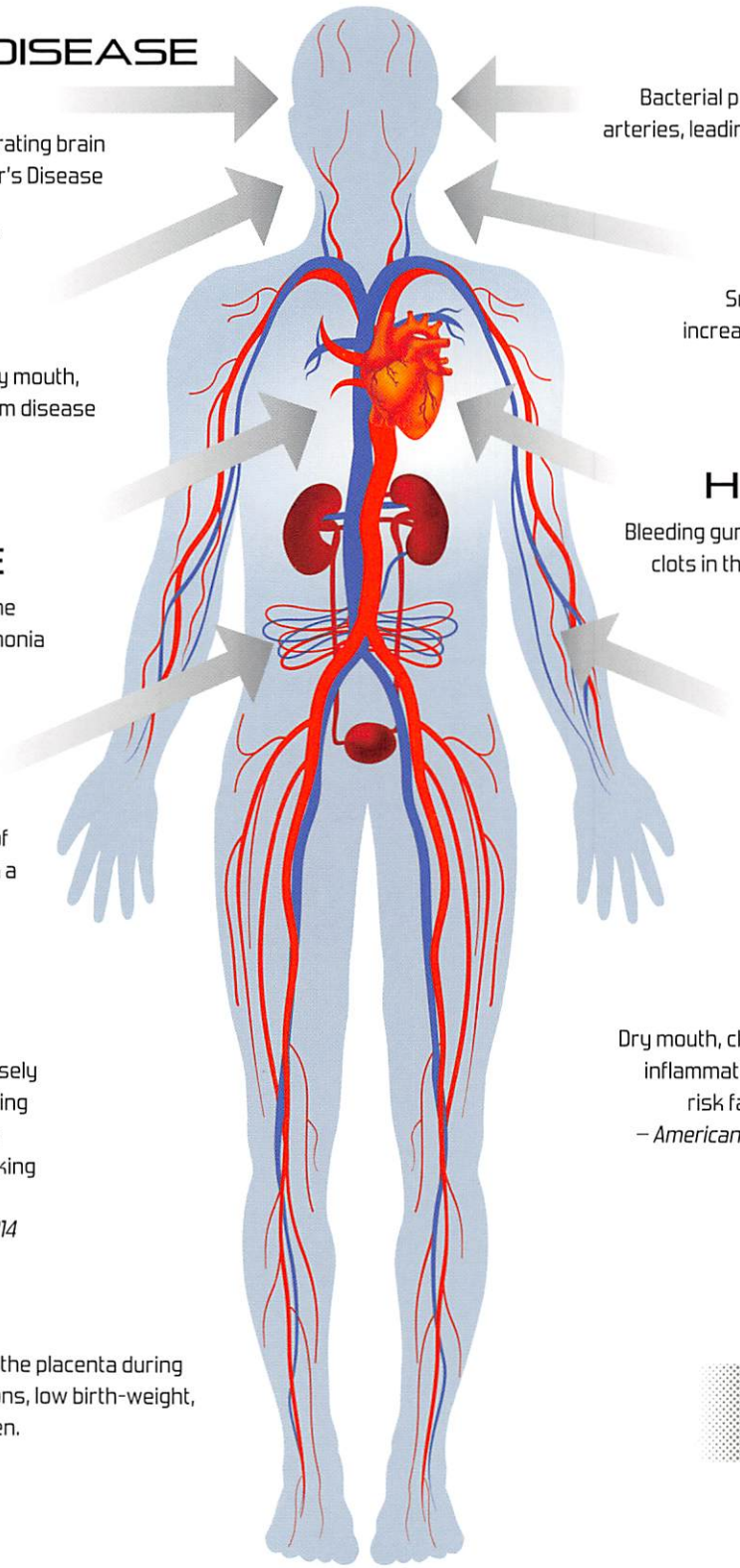
Obese people have a 76% higher rate of periodontal disease than people within a normal weight range.
– National Institutes of Health, 2012

DIABETES

Gum disease and diabetes are very closely related. Diabetes can compromise healing from oral infections and oral infections alters sugar processing, therefore making diabetes more difficult to control.
– Harvard University Medical School, 2014

PREGNANCY

Oral bacteria has been shown to cross the placenta during pregnancy and can lead to fetal infections, low birth-weight, and premature labor in pregnant women.
– WebMD, 2009



STROKE

Bacterial plaques in the mouth have been found in arteries, leading to a greater risk for clots and stroke.
– Columbia University, 2005

SMOKING

Smoking dulls taste and smell sensation, increases oral cancer risk, and compromises healing from oral infections.
– American Dental Association, 2017

HEART DISEASE

Bleeding gums increase the likelihood of developing clots in the circulatory system and increases the changes of stroke by more than 50%.
– American Heart Association, 2016

HIGH BLOOD PRESSURE

Gum disease increases inflammatory markers that raise a person's risk for high blood pressure and stroke.
– WebMD, 2003

SLEEP APNEA

Dry mouth, clenching and grinding, chronic systemic inflammation, chronic fatigue, and even death are risk factors when sleep apnea is not treated.
– American Academy for Oral Systemic Health, 2012

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PATIENT REGISTRATION

Patient Information:

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____ Social Security #:_____ Drivers License#:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

E-mail:_____ ○ I would like to receive correspondences.

Whom may we thank for referring you?_____

If not referred, did you find us online? Source: ○ Yelp ○ Google ○ Other_____

Preferred Pharmacy/Hospital:_____ Phone#/Location:_____

Emergency Contact:_____ Emergency Contact#:_____

○ Primary Policy Holder ○ Responsible Party is Policy Holder for Patient ○ Secondary Policy Holder

Responsible Party: ○ Same as above.

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth date:_____ Social Security#:_____ Drivers License#:_____

Insurance Information:

Name of insured:_____ Relationship to patient:_____

Insurance company:_____ State (if applicable):_____ DOB__/__/__

Group#:_____ Policy ID#:_____

Insurance Address:_____ City:_____ State/Zip:_____

DO YOU HAVE SECONDARY INSURANCE? ○ Yes ○ No IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured: _____ Relationship to patient:_____

Insurance company:_____ State (if applicable):_____ DOB__/__/__

Group#:_____ Policy ID#:_____

Insurance Address: _____ City:_____ State/Zip:_____

Eaglesoft Medical History(Copy)(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Height?		
Weight?		
Have you ever been hospitalized or had a major operation within the last 3 years?	Yes No	If yes
Are you under a physician's care now? (Please include name and contact information for MD).	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, drugs and/or pre-med?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken prescription medication for osteoporosis (Fosamax, Boniva, Actonel, Areta)?	Yes No	If yes
Do you use any tobacco products and/or vape?	Yes No	If yes

Women: Are you...

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

☐ Trying to get pregnant?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	Yes No	If yes	
Do you use controlled substances?	☐	If yes	
Men: Are you actively taking male enhancement medications, i.e. Viagra, Cialis or Levitra?	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed	Yes No	If yes	

FOR DIABETIC PATIENTS ONLY

Latest HbA1c results?	
Date of last blood test taken?	

Comments:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

OFFICE FINANCIAL POLICY

FINANCIAL POLICY: Please remember that you are fully responsible for all fees charged by this office regardless of your insurance coverage.

DENTAL INSURANCE:

- Our office will assist you in obtaining the maximum benefits specified in your contract. However, your benefits are a contract between you, your employer and carrier. We will assist you in determining your benefits as best we can. Because plans differ from carrier to carrier and policy to policy, our office may refer you to your carrier or your employer's HR coordinator for assistance in understanding your plan.
- As a courtesy to our patients we will file your benefits claim and accept estimation of benefits (EOB). We ask that your estimated co-payments and deductibles be paid at the time of service. Pre-Authorizations are not a guarantee of benefits and coverage.
- Balances with outstanding benefit claims outstanding of more than 60 days may be reverted back to the patient.
- We understand you may change insurance carrier(s) during your treatment process. To accommodate this change we will honor your previous carrier(s) fees for up to 6 months prior to your first initial visit with our office.
- We do not issue refunds for patients with pending treatment unless requested.

PATIENT PORTION:

Any estimated amounts due and payable by the patient (including co-pays and deductibles) are due on, or by the day that services are rendered unless other arrangements have been made in advance.

Method of payment

- PPO insurance policies: Dental and Medical
- Cash, Check, Visa, Mastercard, Discover and American Express
- Healthcare Savings Account/Flexible Spending Account

AGED ACCOUNTS:

- A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days.
- In the event that your account is not paid we will refer your account to a collection agency, you will be responsible for all fees incurred for the collection of your bill (i.e., attorney fees, court costs and collection agency fees).

BROKEN/MISSED APPOINTMENTS: Missed or broken appointments prevent others from receiving the dental care they deserve. To cancel or reschedule an appointment, we kindly request you notify us at least 48 hours in advance to avoid a missed appointment fee of $50.00. Rescheduling surgical appointments may require a deposit at Doctors discretion.

AUTHORIZATION, RELEASE & PAYMENT AGREEMENT FOR SERVICES RENDERED:

_____ I authorize the doctor and or staff to contact me regarding; appointments, accounting and follow-ups on the telephone numbers listed, including work and cellular phone.

_____ I authorize the doctor and or staff to release and provide copies of any or all clinical treatment records and information concerning my care to third party payers and/or health practitioners.

_____ I assign directly to Ueno Periodontics all benefits, if any, otherwise payable to me for services rendered by third party payers.

_____ I understand that my dental benefits may pay less than the estimated coverage cost. I agree to be responsible for the payment of all services rendered on my behalf or on the behalf of my dependent

_____ _____

Patient signature or parent/guardian Date

PHOTOGRAPHY RELEASE

I, _____, hereby authorize Ueno Periodontics, or any assistants and affiliates to take photographs, slides and/or videos of my face, jaws, mouth and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations and professional publications (journals, magazines).

I further understand that if the photographs, slides and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect/require compensation; financial or otherwise, for the use of these photographs

_____ _____

Signature Date

UENO CENTER

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____

_____ _____
Staff Member Signature Date

Effective 01/2011

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Dental Practice Covered By This Notice

This Notice describes the privacy practices of UENO CENTER ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

How to Contact Us/ Our Privacy Official

If you have any questions or would like further information about this Notice, you can either write to or call the Privacy Official for our Dental Practice:

Dental Practice Name:	Ueno Center
Privacy Official for Dental Practice:	Diem Nguyen
Dental Practice mailing address:	2160 S. Bascom Ave. Suite #1 Campbell, CA 95008
Dental Practice email address:	diem@ueno.center
Dental Practice phone number:	(408) 371-7616

Information Covered By This Notice

This Notice applies to health information about you that we create or receive and that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- Maintain the privacy of your health information.
- Give you this Notice of our legal duties and privacy practices with respect to that information.
- Abide by the terms of our Notice that is currently in effect.

Our Use and Disclose of Your Health Information Without Your Written Authorization

Common Reasons for Our Use and Disclosure of Patient Health Information

Treatment: We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment: We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations: We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders: We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, or email.

Treatment Alternatives and Health-Related Benefits and Services: We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends: We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information

The following uses and disclosures occur infrequently and may never apply to you.

Disclosures Required by Law: We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

Public Health Activities: We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities: We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions: We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes: We may disclose patient health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors: We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Organ, Eye and Tissue Donation: We may use or disclose patient health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

Research Purposes: We may use or disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety: We may use or disclose patient health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Specialized Government Functions: We may disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation: We may disclose patient health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

We will make other uses and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

Access: You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

Amend: If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

Restrict Use and Disclosure: You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception. If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

Confidential Communications: Alternative Means, Alternative Locations. You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

Receive a Paper Copy of this Notice: You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

We Have the Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is in the top right-hand corner of the Notice.

To Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.