Trevor Tsuchikawa
DDS PLLC

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Patient Information

Name_____ **Birth Date**_____ **Sex**_____

Soc. Sec. #_____ **Home Ph**_____ **Cell Ph** _____

Address_____ **City**_____ **State**_____ **Zip**_____

Email_____ **Driver License #**_____

Preferred Method of Confirmation (Circle One): ❑ **Text** ❑ **Call** ❑ **Email**

How did you hear about our office? (Check All That Apply) ❑ **Google** ❑ **Website**

❑ **Friend** _____ ❑**Patient** _____

Person to Contact in Case of Emergency _____

Phone #_____

Insurance Information

Name of Insured _____ **Relationship to Patient** _____

Birthdate _____ **Social Security #** _____

Insurance Company_____**Group #**_____

Policy/ID #_____ **Ins. Co. Address** _____

City_____ **State** _____ **Zip**_____

*If you have a secondary dental insurance please let us know.

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____ **Contact #** _____

Birth Date _____ **SSN #** _____

Patient Medical History

Patient Name_____ Birth Date_____

	Yes	No
Are you under a Physician's care now?	☐	☐
Have you ever been hospitalized or had a major operation?	☐	☐
Have you ever had a serious head or neck injury?	☐	☐
Are you taking any medications, pills or drugs?	☐	☐
Do you take, or have you taken, Fosamax or Bisphosphonate?	☐	☐
Are you on a special diet?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Women: Are you		
Pregnant or trying to get pregnant?	☐	☐
Nursing?	☐	☐
Taking oral contraception?	☐	☐

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other
If Yes, please explain:_____

Do you have, or have you had, any of the following? (Check all that applies)

☐AIDS/HIV
☐Alzheimer's Disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/Gout
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Breathing Problems
☐Bruise Easily
☐Cancer
☐Chemotherapy
☐Chest Pains
☐Cold Sores/Fever Blisters
☐Congenital Heart Disorder
☐Convulsions
☐Cortisone Medicine
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Excessive Thirst
☐Fainting Spells/Dizziness
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headaches
☐Genital Herpes
☐Glaucoma
☐Hay Fever
☐Heart Attack/Failure
☐Heart Murmur
☐Heart Pacemaker
☐Heart Trouble/Disease
☐Hemophilia
☐Hepatitis A
☐Hepatitis B or C
☐Herpes
☐High Blood Pressure
☐Hives or Rash
☐Hypoglycemia
☐Irregular Heartbeat
☐Kidney Problems
☐Leukemia
☐Liver Disease
☐Low Blood Pressure
☐Lung Disease Mitral Valve
☐Prolapse Pain in Jaw Joints
☐Parathyroid Disease
☐Psychiatric Care Radiation
☐Treatments Recent Weight
☐Loss Renal Dialysis
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Spina Bifida
☐Stomach/Intestine Disease
☐Stroke
☐Swelling of Limbs
☐Thyroid Disease
☐Tonsillitis
☐Tuberculosis
☐Tumors or Growths Ulcers
☐Venereal Disease
☐Yellow Jaundice
☐Other:_____

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 my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Name_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our 'Notice of Privacy Practices', which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's 'Notice of Privacy Practices'.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our 'Notice of Privacy' from this patient but it could not be obtained because:

The patient refused to sign.
Due to an emergency situation it was not possible to obtain acknowledgement.
We weren't able to communicate with the patient.
Other (Please provide specific details)

Employee signature

Date

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, [illegible] information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.