Oracare Dental
Joseph O. Paraiso, D.M.D.

Welcome to Our Practice

We would like to welcome you to our office and thank you for selecting us to be responsible for your dental health needs. We are here to serve you in a comfortable and professional atmosphere. Please review our policy to become more familiar with our philosophy and procedures.

STERILIZATION

We provide a safe dental environment for all of our patients. WE FULLY COMPLY with ALL OSHA and government regulations and guidelines to help ensure your protection.

TREATMENT ESTIMATES AND INSURANCE

In most cases, we are able to give **estimates** based upon X-rays and examinations, however, we cannot be absolutely certain of scope of work needed until actually starting the treatment. As a courtesy to our patients, we will file claim to insurance company for services rendered. Due to variations in dental insurance contracts, it is not always possible to determine exact benefits. While we attempt to provide an estimate of coverage, you are encouraged to contact your insurance company directly to confirm what they will and will not cover since you will be responsible for all services rendered. If, for any reason your insurance company has failed to pay within a reasonable period of time, we must ask that you pay your bill and seek reimbursement from your insurance company.

FEES AND PAYMENT POLICY

In an effort to keep dental costs down while maintaining a high level of professional care, we ask for payment at the time services are rendered. For your convenience, we accept cash, personal checks and credit cards. We also take CareCredit, with 0% interest for 3, 6 and 12 months on approved credit. There will be a $35.00 fee for any check that is returned to us from your bank.

DUPLICATING FEE

When requesting copies of X-rays or dental records, there will be a duplicating fee. By law, we must keep the original records and X-Rays for minimum of 6 years.

APPOINTMENT TIME

We exclusively set time for our patients and request a **48-hour notice** for any changes in the scheduled appointment time. There will be a **$50.00** charge for any appointment missed or rescheduled less than 48 hours in advance.

Patient's Name (print): _____

Patient's Signature: _____ Date: _____

Welcome

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Birthdate _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Phone (____) _____ Work (____) _____ Ext _____ Alt. Phone (____) _____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (____) _____ Work Phone (____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Clicking or popping jaw	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Dry mouth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Lip or cheek biting	☐ Yes	☐ No	How often do you floss?		
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush?		

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			
Do you wear contact lenses?	☐ Yes	☐ No						

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

Updates *(To be filled in at future appointments)*

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Protecting Your Confidential Health Information is Important to Us

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.

Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

ORACARE DENTAL
Dr. Joseph O. Paraiso
(650) 917-1077

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

Patient Acknowledgment

Patient Name(s): _____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

_____

Patient Signature

Date _____ / _____ / _____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

Proteger su información de salud confidencial es importante para nosotros

Aviso de prácticas de privacidad

Este aviso describe la manera en que la información de salud referente a usted puede ser usada y revelada, y cómo puede usted tener acceso a esta información. Por favor lea cuidadosamente.

Nuestra promesa!

Estimado Paciente:

Esto no lo debe alarmar! Absolutamente lo contrario!
Es nuestra intención comunicarle que estamos tomando las nuevas leyes (Acta de Aseguranza Portabilidad y Responsabilidades de la Salud de 1996 "AAPRS") escritas para proteger la confidencialidad de la información de su salud con seriedad.
No queremos que alguna vez se retrase su tratamiento porque esté temeroso acerca de su historial de salud personal sea innecesariamente hecho por otras personas fuera de nuestras oficinas.

¿Entonces qué ha cambiado? ¿Porqué una política de privacidad ahora? ¡Muy buenas preguntas!

La variable más significante que ha motivado al gobierno Federal a hacer cumplir legalmente la importancia de de la privacidad de la información de la salud es la rápida evolución de la tecnología de las computadoras y su uso en la cuidado de la salud.
El gobierno ha buscado de manera apropiada el estandarizar y proteger la privacidad del intercambio electrónico de su información de salud. Esto nos ha desafiado a checar no solamente cómo su información de salud es usada por medio de las computadoras, sino también por Internet, teléfono, faxes, copiadoras y cartas.
Creemos que esto ha sido un excelente ejercicio para nosotros porque nos ha disciplinado a poner por escrito las políticas y procedimientos que usamos para asegurarnos de la protección de su información de salud en donde quiera que sea usada.

Queremos informarle acerca de estas políticas y procedimientos que hemos desarrollado para asegurarnos de que su información de salud no será difundida o compartida con alguien que no lo requiera.
Nuestra oficina está sujeta al a las leyes Federales y Estatales de acuerdo a la confidencialidad de su información de salud y en cuanto al almacenamientos de esta información, queremos que usted entienda nuestros procedimientos y sus derechos como nuestro apreciable paciente.

Usaremos y comunicaremos su INFORMACION DE SALUD solamente para fines de proveerle un tratamiento, obtener el pago y dirigir operaciones en el cuidado de su salud. Su información de salud no será usada para otros fines a menos que le hayamos preguntado y usted nos haya concedido una autorización por escrito.

ORACARE DENTAL • (650) 917-1077
www.oracaredental.com

¿Cómo puede ser usada su INFORMACION DE SALUD?

Para darle tratamiento

Usaremos su información de salud dentro de nuestra oficina para ofrecerle el mejor cuidado dental posible. Esto puede incluir procedimientos administrativos y clínicos designados para optimizar su calendario y coordinación del cuidado entre el higienista, asistente dental, dentista y el personal de oficina. Además, podemos compartir su información de salud con médicos, refiriéndonos a dentistas, laboratorios clínicos y dentales, farmacias y más personal del cuidado de la salud que este atendiento su tratamiento.

Para obtener el pago

Podemos incluir en su información de salud una factura usada para cobrar el pago del tratamiento que recibió en nuestra oficina. Podríamos hacer esto con formas de la aseguranza llenadas por usted por correo o enviadas electrónicamente. Estaremos seguros de solamente trabajar con compañías con procedimientos similares con la seguridad de su información de salud.

Para dirigir operaciones de cuidado médico

Su información de salud puede ser usada durante funciones de evaluación de nuestro personal. En algunas de nuestras mejores oportunidades de enseñar se utilizan situaciones clínicas experimentadas por pacientes que reciben atención en nuestras instalaciones. Como un resultado. La información de salud puede ser incluida en programas de entrenamiento para estudiantes, internos, asociados y empleados clínicos y de negocios. También es posible que la información de salud sea revelada durante auditorías por compañías de seguros o agencias gubernamentales citadas como una parte de su aseguramiento de calidad y chequeos normativos. Su información de salud puede ser revisada durante procesos de certificación rutinaria y actividades licensiamiento o credencialización.

En recordatorios de pacientes

Porque creemos que el cuidado regular es importante para su salud oral y general, le recordaremos de su cita programada o de que es tiempo de que nos contacte para hacer una cita. Adicionalmente, lò podríamos contactar para darle seguimiento en su cuidado e informarlo de sus opciones de tratamiento o servicios que podrían ser de su interés para usted o su familia.
Estos comunicados son una parte importante de nuestra filosofía de asociación con nuestros pacientes para estar seguros que ellos reciben el mejor y moderno cuidado restaurativo dental. Pueden ser incluidos tarjetas postales, tarjetas postales carpeta, cartas, recoradatorios telefónicos, recordatorios electrónicos como email (a menos que usted nos indique que no quiere recibir estos recordatorios)

Abuso o negligencia

Notificaremos a las autoridades gubernamentales si creemos que un paciente ha sido víctima de abuso, negligencia o violencia doméstica. Haremos esta revelación solamente cuando estemos obligados por nuestro juicio ético, cuando pensemos que estamos específicamente requeridos o autorizados por la ley o con el acuerdo del paciente.

Salud Pública y Seguridad Nacional

Podríamos ser requeridos a declarar información de salud con oficiales Federales o autoridades militares para completar alguna invetigación relacionada con la salud pública o la seguridad nacional.
La información de salud podría ser importante cuando el gobierno crea que la seguridad pública podría beneficiarse cuando la información pueda llevar al control o prevención de una epidemia o al entendimiento de nuevos efectos laterales de un tratamiento o un dispositivo médico.

Para la aplicación de la ley

Como se permita o se requiera por la ley Estatal o Federal, podríamos revelar su información de salud a algún oficial de la ley para ciertos con fines del cumplimiento de la ley, incluyendo bajo algunas circunstancias limitadas, si usted es víctima de un crímen o a favor de reportar un crímen.

Familia, amigos y personas que lo cuiden.

Podríamos compartir si información de salud con aquellos que usted nos indique que lo estarán ayudando con el aseo de su hogar, tratamiento, medicamentos, o pago. Nos aseguraremos de pedirle una autorización primero. En el caso de una emergencia, donde usted esté imposibilitado para decirnos lo que quiere nosotros usaremos nuestro mejor juicio para saber a quién compartirle su información de salud, solamente cuando sea importante para que ellos participen cuidando de usted.

Autorización para usar o revelar información de salud.

Con expeción de las listadas anteriormente o donde la leyes Federales, Estatales o Locales nos lo requieran, no revelaremos su información de salud a menos que usted lo autorize por escrito. Usted puede revocar esa autorización por escrito cuando quiera.

Confirmación del paciente

Nombre(s) del paciente: _____

_____

_____

Muchas gracias por tomarse el tiempo para revisar la manera en que usamos cuidadosamente su información de salud. Si tiene alguna pregunta queremos escucharlo. En caso contrario, apreciaríamos mucho su confirmación de recibo de nuestra política al firmar y regresar esta tarjeta. Esperamos verlo de nuevo pronto!

_____

Firma del paciente
Fecha _____ / _____ / _____

Derechos del paciente

Esta nueva ley es cuidadosa al describir que usted tiene los siguientes derechos relacionados con su información de salud.

Restricciones

Usted tiene el derecho de solicitar restricciones en ciertos usos y revelaciones de su información de salud. Nuestra oficina hará todos los esfuerzos para disponer de restricciones razonables para sus pacientes.

Comunicaciones confidenciales

Usted tiene el derecho de solicitar que nosotros nos comuniquemos con usted de alguna manera. Usted puede solicitar que nosotros solamente le comuniquemos su información de salud privadamente sin algún miembro de su familia presente o a través de comunicación por correo sellado. Haremos el mejor esfuerzo por cumplir sus solicitudes razonablespara comunicaciones confidenciales.

Examine y copie su información de salud

Usted tiene el derecho de leer, revisar, y copiar su información de salud, incluyendo su historial completo, rayos X, rpecord de pagos. Si usted quisiera una copia de su información de salud, por favor infórmenos. Podríamos vernos en la necesidad de hacer un cargo razonable para duplicar y completar su copia.

Modificaciones a su Información de Salud

Usted tiene el derecho de solicitarnos la actualización o modificación de su información si usted cree que la información de su salud están incorrectos o incompletos. Con gusto mantendremos estos datos durante el periodo que nuestra oficina mantenga esta información. Para estandarizar nuestro proceso, por favor dénos su solicitud por escrito y describa su razón para solicitar la modificación o cambio.

Documentación de la Información de Salud

Usted tiene el derecho de solicitarnos una descripción de cómo y dónde fue usada su información de salud por nuestra oficina por alguna razón diferente a la de su tratamiento, pago u operaciones de salud. Nuestros procesos de documentación nos permitirán proveerle la información usada de Abril 14, 2003 en adelante. Por favor indíquenos por escrito el periodo de tiempo en el que está interesado. Gracias por limitar su solicitud a no más de seis años en una vez. Podríamos vernos en la necesidad de hacer un cargo razonable por su solicitud.

Solicitud de una copia de papel de este Aviso

Usted tiene el derecho de obtener una copia de este Aviso de Prácticas de Privacidad directamente de nuestra oficina cuando usted lo requiera. Venga o llámenos y le enviaremos por correo o correo electrónico una copia.
La ley nos requiere que mantengamos la privacidad de su información de salud y que se la proveamos y a su representante este Aviso de nuestras Prácticas de Privacidad. Estamos obligados a practicar las políticas y procedimientos descritos en este aviso pero nos reservamos el derecho de cambiar los términos de nuestro Aviso. Si cambiáramos nuestras prácticas de privacidad nos aseguraremos de que todos nuestros pacientes reciban una copia del Aviso corregido.

Usted tiene el derecho de expresar sus quejas hacia nosotros o a la Secretaría de Salud y Servicios Humanos si usted cree que sus derechos de privacidad han sido comprometidos. Lo invitamos a que exprese cualquier preocupación que pueda tener referente a la privacidad de información. Por favor déjenos saber acerca de sus preocupaciones o quejas por escrito.

#PM-00049 • Printed in U.S.A.
©SmartPractice® 1-800-522-0833

Patient Screening Form

ADA.

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.