Hello and Welcome To Our Office!

This package contains the Patient Record form, Medical History form, Dental History form, Financial Policy Information, Insurance Information and HIPAA Information. Prior to your appointment, we ask that you completely fill out the Patient Record, Medical History and Dental History forms and bring them to your exam appointment. In addition, please bring any notes and x-rays from your referring dentist.

You are scheduled for an exam on______________________________.

If unable to keep your appointment, kindly give 2 business days notice or a broken appointment fee will incur. For Monday appointments, we require cancellation no later than the prior Thursday as our office is closed on Fridays.

Please be advised that all payments including insurance and co-payments are payable on the day of your appointment. We accept cash, check, Visa, American Express, and MasterCard.

Please call us if you have any questions prior to your appointment. We look forward to meeting you!

Sincerely,

Dr. Stephen John and Staff

STEPHEN R. JOHN, DDS, APC *Periodontics, Dental Implants and Laser Therapy*

PERSONAL RECORD

PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY

Responsible Party____
(Last) (First) (Middle)

Patient Name____
(Last) (First) (Middle)

Social Security Number___________________________ Driver's license state & number_________________________

Street Address____
(Address/Street) (City) (Zip Code)

Billing Address (if different)____

Phone (Home)______________________ Phone (Cell)_____________________ Phone (Work)___________________

Sex_______ Marital Status________ Birthdate____________ Physician_______________________________________

General Dentist____________________________________ Referred by (if different)____________________________

Emergency Name & contact #____

"I have received the Notice of Privacy Practices and have been provided an opportunity to review it"

Signature____ **Date**________________________

INSURANCE INFORMATION ***Your insurance cannot be processed unless all information is provided***

Insured by: Self/Parent [ ] Spouse/Partner [ ] Both [ ] *Fill out both sections

PRIMARY INSURANCE (Self/Patient/Parent)	**SECONDARY INSURANCE (Spouse/Partner)**
Name____________________________	Name____________________________
Dental Insurance__________________	Dental Insurance__________________
Employer_________________________	Employer_________________________
Address__________________________	Address__________________________
Group/Union #_____________________	Group/Union #_____________________
Social security #___________________	Social security #___________________
Birthdate_________________________	Birthdate_________________________

"I authorize the holder of any pertinent dental information about me to release to my insurance company any information needed for this and any related claim and I authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I hereby permit this signature to be used in lieu of on the original insurance form."

Signature____ **Date**________________________

STEPHEN R. JOHN, DDS, APC *Periodontics, Dental Implants and Laser Therapy*

MEDICAL HISTORY

Your general health is an important factor and may influence the course of periodontal disease. To aid in establishing a thorough diagnosis and treatment, please complete this history form.

Please Circle

1. Do you consider yourself to be in good health? **YES NO ?**

2. Do you need to take a premedication (antibiotic) prior to your dental appointment for :
   Heart Condition? **YES NO ?**
   Hip Replacement or Knee Replacement? **YES NO ?**
   Other______________________________________ **YES NO ?**

3. Are you being treated by a physician now? **YES NO ?**
   If so, what for?___________________________________

4. Have you been hospitalized or had surgery within the last two years? **YES NO ?**
   IF so, what for____

5. Are you taking any medications? What are they? **YES NO ?**
   [ ] Antibiotic___________________________________ [ ] Blood Pressure Medicine_________________________
   [ ] Aspirin_____________________________________ [ ] Anti-Coagulants__________________________________
   [ ] Diabetic medicine___________________________ [ ] Birth Control pills_______________________________
   [ ] Hormones___________________________________ [ ] Steroids____
   [ ] Bisphosphonate______________________________ [ ] Sedatives____
   [ ] Other____

6. Have you had any of the following conditions? **YES NO ?**
   [ ] Heart Disease [ ] High Blood Pressure [ ] Valve Defect [ ] Arterial Stent
   [ ] Stroke [ ] Blood Disease/anemia [ ] Excessive Bleeding [ ] Kidney Disorder
   [ ] Hepatitis/Jaundice [ ] Liver Disease [ ] HIV Related Problems [ ] Venereal Disease
   [ ] Diabetes [ ] Skin Disease [ ] Arthritis/Joint Problems [ ] Auto Immune Disease
   [ ] Respiratory Disorder [ ] Tuberculosis [ ] Asthma/Hay Fever [ ] Sinus Problems
   [ ] Epilepsy [ ] Emotional Problems [ ] Emotional Stress [ ] Glandular Disorder
   [ ] Other____

7. Have you become sick, shown an allergy to, or been told not to take? **YES NO ?**
   [ ] Penicillin/Amoxicillin/Keflex [ ] Erythromycin [ ] Tetracycline [ ] Cleocin/Clindamycin
   [ ] Barbiturates/Sedatives [ ] Valium [ ] Codeine [ ] Vicodin
   [ ] Local Anesthetics (Novacaine) [ ] Latex [ ] Aspirin [ ] Other___________________________

8. Do you smoke? How much?___________ PPD___________ **YES NO ?**

9. Have you ever had Chemo or Radiation therapy for cancer? **YES NO ?**

10. Women: Are you pregnant? What Trimester?___________ **YES NO ?**

11. Do you have any other condition not listed?______________ **YES NO ?**
    What?____

Signature____ **Date**____________________

STEPHEN R. JOHN, DDS, APC *Periodontics, Dental Implants and Laser Therapy*

DENTAL HISTORY

1. Dental complaint at the moment____

2. How long have you been aware of your periodontal problem?______________________________________
3. Are you experiencing discomfort from your mouth at this time? **YES NO ?**
4. Have you had previous periodontal treatment?____
   (When) (Where)
5. Do your gums ever bleed when you brush your teeth? **YES NO ?**
6. Are your gums receding? **YES NO ?**
7. Have you noticed any mouth odors or bad breath? **YES NO ?**
8. Do you suffer from pain and/or swelling of your gums? **YES NO ?**
9. Have you ever had a sore mouth, trenchmouth or pyorrhea? **YES NO ?**
10. Are any of your teeth sensitive to heat, cold, chewing and/or sweats? **YES NO ?**
11. Have you noticed any loosening of your teeth? **YES NO ?**
12. Have you noticed drifting/movement of your teeth? **YES NO ?**
13. Do you develop cold sores, canker sores, fever blisters or other sores? **YES NO ?**
14. Have you ever had your teeth straightened? **YES NO ?**
15. Do you often find yourself clenching and/or grinding your teeth? **YES NO ?**
16. Do you ever experience sounds in the joints of your jaw? **YES NO ?**
17. Do you suffer from pain or sensitivity of the joints of your jaw? **YES NO ?**
18. Have you ever been treated for pain in the jaw joint? **YES NO ?**
19. Have you ever had an occlusal adjustment or your teeth ground to improve your bite? **YES NO ?**
20. Have you ever had a bad reaction to a dental anesthetic? **YES NO ?**
21. Have you ever had a complication following dental surgery or treatment? **YES NO ?**
22. Do you have anxieties about dental procedures? **YES NO ?**
23. How often do you have your teeth cleaned by a dentist or hygienist?________________________________

24. When was your last professional cleaning?____
25. Do you know what dental plaque/bacteria is? **YES NO ?**
26. How often do you brush your teeth?____

27. What do you use to clean in between your teeth?____
28. Do you use a mouthwash/rinse regularly? **YES NO ?**

Signature____ **Date**_________________

FINANCIAL POLICY

"I have been provided a complete copy of Dr. Stephen John's financial policy. I have read and understand the Financial Policy. All questions have been answered."

Signature____ **Date**_________________

STEPHEN R. JOHN, DDS, APC ***Periodontics, Dental Implants and Laser Therapy***

FINANCIAL POLICY

General Information

1. **We require all forms to be completed accurately and in full.**
2. **We require the social security number of every adult patient, the insurance subscriber and the responsible parent of our minor patients.**
3. **Should the patient elect not to provide their SS#, we require cash payment in full for all services at the time of service.**
4. **Payment in full is due at the time of service. (See below if you are insured). We do not bill patients or send out statements.**
5. **We accept checks, cash, Visa, MasterCard and American Express.**
6. **We have no in-house financing. However, we do offer excellent third party financing options through Care Credit. If interested, please ask the front desk about financing options prior to scheduling treatment as financial arrangements must be made at least one week prior to your treatment date; otherwise payment is due at the time of service. NO EXCEPTIONS**
7. **If unable to keep your appointment, kindly give 2 business days notice or a broken appointment fee will incur.**

Insurance Information

1. **Dental Insurance is a contractual agreement between your employer and insurance company. The percentage of reimbursement varies greatly dependent upon the premiums paid for a particular plan and limitations of the agreement.**
2. **Maximum payable benefits around $1000-$1500 commonly found today with dental insurance plans are almost identical to the annual maximum benefits of dental insurance plans 40 years ago.**
3. **Dental insurance is a benefit designed to help defray the costs of quality dental care, but is not all-inclusive of what an individual may need or desire to obtain optimal dental health for a lifetime.**
4. **Every insurance policy has limitations. It is the responsibility of the patient, not the dental office, to be aware of such limitations.**
5. **As a courtesy to our patients, this office agrees to submit a one-time insurance claim for "covered" services. This office allows 45 days from the date of service for the account to be settled. All unpaid insurance claims, correspondence and follow-up with the insurance company is the patient's responsibility. Overdue or unpaid account balances are subject to late fees and collection.**
6. **We require accurate and up to date insurance information a minimum of 2 business days prior to the appointment. If the information is not provided within 2 business days, we require payment from the patient at the time of the appointment.**
7. **We do the best that we can to "*Estimate*" the amount of your co-payment. The "ESTIMATED" co-payment is due at the time of service. The copayment can change due to pending claims, incorrect information given to us by the insurance company or a change in coverage. Any outstanding balance is the responsibility of the patient.**
8. **We welcome patients with Blue Cross/ Blue Shield coverage. However, we are not contracted with either of these companies. Therefore, we require payment in full from the patient at the time of service. We will provide a claim form and necessary documentation should you choose to submit the claim to your insurance company. The claim form directs the insurance company to reimburse the patient directly.**

FINANCIAL POLICY-Continued

Important Notice To Our Patients

1. **Each time a patient misses an appointment without providing notice, another patient is prevented from receiving care. While we make every attempt with automated appointment reminder phone calls, some phones either do not accept the reminder notice or the call attempt fails.**
2. **Patients are responsible for keeping their appointed times, whether or not they receive a reminder call.**
3. **If unable to keep your appointment, kindly give 2 business days notice or a broken appointment fee will incur.**
4. **Each broken exam or cleaning appointment will be subject to a $50 fee. Each broken root planning or surgery appointment will be subject to a $100 fee.**
5. **Broken appointment fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next scheduled appointment. Multiple broken appointments may result in termination from our practice.**
6. **We appreciate your understanding and cooperation as we strive to serve the best needs of all our patients.**

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/01/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

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

If you are concerned that we may have violated your privacy rights, or if 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 complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Dr. Stephen R. John

Telephone: 650-571-1900 Fax: 650-571-8116

Address: 228 De Anza Blvd, San Mateo, Ca 94402

WHAT IS HIPAA AND WHY DO I HAVE TO FILL OUT AND SIGN ALL OF THESE FORMS?!

A SIMPLIFIED EXPLANATION.

In 1996, congress passed the Health Insurance Portability and Accountability Act. The act is to *insure* the privacy of your dental and medical information, to clarify who is entitled to *access* your information, to create a system of *ease* of transfer of this information and to make sure that we are *accountable* in protecting your information.

If you would like anyone like your spouse, significant other, children, friends, etc to have access to any of your dental records please sign a specific written release (Authorization Form for Use or Disclosure of Patient Information) to share your information with the specified individual or individuals.

Please seriously consider who you want your information shared with. You can give different individuals different access to various parts of you records. If you elect NOT to sign the form, we can not and will not release any information to anyone else other than you. If at a later date you wish to make changes on who can access you records, please fill out the Authorization Form for Use or Disclosure of Patient Information with the updated information. We can send you this form or it is available on my website for you to print.

If a specific individual requests your records or if you want us to send your records to someone, we also have a Release of Records form for you to fill out and send us. We can send you this form or it is available on my website for you to print.

Authorization Form for Use or Disclosure of Patient Information

Patient Name:____ DOB___________

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

INDIVIDUAL GIVEN PERMISSION TO ACCESS RECORDS CHECKED BELOW:

(Full Name)	Relationship to Patient
(Full Name)	Relationship to Patient
(Full Name)	Relationship to Patient
(Full Name)	Relationship to Patient
(Full Name)	Relationship to Patient

PLEASE CHECK WHAT YOU ARE AUTHORIZING:

____ The above individuals have access to all of my records.

OR

___ The above individuals only have access to the records checked below:

- ___ Personal Record
- ___ Medical History Record
- ___ Dental History Record
- ___ Periodontal charting and Radiographs
- ___ Treatment Record (Completed Treatment)
- ___ Treatment Plan (Future Treatment)
- ___ Financial History (Account and Patient Ledger)
- ___ Prescription History
- ___ Laboratory results/ findings
- ___ Make Change and/or Cancel Appointments

I understand that I may revoke or alter this authorization at any time, and that my change is not effective unless it is in writing and received by the dental practice's Privacy Official at 228 De Anza Blvd, San Mateo, Ca 94402. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

This authorization expires on the following date, or when the following event occurs:

___ On _______________________________________(month/day/year or event)

___ I give my consent to "No Expiration Date"

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of Patient or Legal Guardian/Caregiver:

____Date___________________

If Legal Guardian/Caregiver:

Print Name:____

Signature:_________________________________Relationship to Patient:_________________

For office use only: Copy of signed authorization provided to the individual:
Date:______
Initials:_____
Pt Refused to Sign:_____