Confidential Patient Registration & Medical History

PATIENT INFORMATION

Date _____

Patient's Name _____ Preferred Name _____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred method of communication (please circle) Phone Text E-mail _____

Sex: ☐ M ☐ F Age_____ Birthdate _____

PATIENT MEDICAL HISTORY

Physician _____ Phone _____ Last Exam _____
Are you under medical treatment now? (please list) _____
Have you been hospitalized within the last five years? (please list) _____
Are you taking any medication at this time? (please list) _____
Have you ever taken Phen-Fen/Redux?_____ Do you use controlled substances? _____
Do you use tobacco or tobacco products in any form? (please list) _____

Women: Are you pregnant or think you may be pregnant? _____ If yes, how many weeks? _____
Are you nursing? _____ Do you take birth control pills?_____

Please circle if you are allergic to: Penicillin Latex Codeine Anesthetics Sulfa Drugs Aspirin Other: _____
Do you premedicate before dental treatment? (please list) _____

Please circle any past or present conditions.

Alcohol/Drug Dependency	Diabetes	Hepatitis A	Psychiatric Problems
Allergies	Epilepsy	Hepatitis B	Radiation Therapy
Anemia	Emphysema	Hepatitis C	Respiratory Problems
Angina Pectoris	Glaucoma	Herpes	Rheumatic Fever
Arthritis	Hay Fever	High/Low Blood Pressure	Seizures/Fainting
Artificial Heart Valve	Frequent Headaches	HIV Infection (AIDS)	Shingles
Artificial Joints or Implants	Heart Attack	Kidney Disease	Sickle Cell Disease
Asthma	Heart Disease	Leukemia	Sinus Problems
Blood Transfusion	Heart Murmur	Liver Disease	Thyroid Problems
Cancer/Chemotherapy	Heart Pacemaker	Lung Disease	Tuberculosis
Congenital Heart Problems	Heart Surgery	Mitral Valve Prolapse	Ulcers
Congestive Heart Disease	Hemophilia	Pneumocystitis	Yellow Jaundice

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Date of Last Exam and X-rays _____
(Please obtain copy of recent x-rays if possible)
Why are you changing dentists? _____

Do your gums bleed while brushing or flossing? _____ Do you clench or grind your teeth? _____

Are your teeth sensitive to hot or cold liquids/foods? _____ Do you snore or have sleep apnea? _____

Do you feel anything unusual in your mouth? _____ Have you had any head, neck or jaw injuries? _____

Do you wear dentures or partials? _____ If yes, placement date _____ Are you interested in whitening your teeth? _____

Circle any problems you have experienced in your jaw joint (TMJ): Clicking Pain Difficulty in opening closing or chewing

Is there any other information we should know regarding your medical or dental health? _____

Have you had orthodontic treatment? _____ Are you interested in straightening your teeth? _____

RESPONSIBLE PARTY

Who is responsible for this account? _____ Relationship to patient _____

Address if different than above _____ Home Phone _____

Social Security # _____ Marital Status _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

If Student, Name of College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Name of Spouse _____ Occupation of Spouse _____

Spouse Employer _____ Spouse Business Phone _____

Person to Contact in Case of Emergency _____ Phone number _____

Please list any other family members that are in our care _____

Whom may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Name of Employer _____ Insured's birthdate _____

Insurance Company Name _____ Insured's ID# _____

Insurance Company Phone Number _____ Group # _____

Do you have additional dental insurance coverage? _____ If yes, name of insured _____

Name of Employer _____ Insured's birthdate _____

Insurance Company Name _____ Insured's ID# _____

Insurance Company Phone Number _____ Group # _____

FINANCIAL POLICY

As a courtesy to you, we will complete and file insurance forms for your dental treatment. *You are responsible for verifying benefits and coverage percentages.* The estimated amount the insurance company will not cover is due at time of treatment unless prior arrangements are made. Charges for patients without insurance coverage are due at the time of treatment unless prior arrangements are made. Charges not paid within 45 days are subject to a finance charge of 1.50% per month (18% annual rate).

AUTHORIZATION AND RELEASE

I authorize the release of any information to third party payors and/or health practitioners. I authorize payment from my insurance company to be issued directly to Dr. McCalley. I agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf. I certify I have read and understand the above information and the information I have provided is accurate.

X_____

Signature of patient

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 PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $30 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Gaylin Gardner Chavez
Telephone: 858-560-1996
Fax: 858-430-0063
E-mail: dds@mccalleydds.com
Address: 4320 Genesee Avenue, Suite 201, San Diego, California 92117

RUSSELL W. MC CALLEY, DDS, INC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____ , have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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