Welcome to our Office!!

Thanks for choosing San Elijo Dental for your general dental needs. We would like to welcome you to our office by taking a few moments to introduce ourselves. Dr Karina Gregg has been a dentist and a resident of the San Diego North County for many years. She enjoys what the community has to offer its residents with the many hiking trails, parks, and breathtaking view. This is why she has chosen to operate her dental practice here, offering San Elijo Hills and Carlsbad residents a close and convenient solution to their dental health. Our team consists of dedicated individuals who are kind, friendly and caring. They are here to ensure a pleasant experience during your visit to our office. Our team includes experienced and energetic people whose goal is to communicate with our patients to provide the best care possible. Please visit us on our website at www.sanelijodental.com for more information about out are office and team.

Our practice offers the benefit of the latest technologies and state-of-the-art equipment that will make your visit comfortable and help you become an interactive and educated partner in your dental care. Digital imaging produces digital x-rays and magnified color pictures of your teeth allowing you to see what the doctor is diagnosing. Comfortable chairs, TV's are available to help with relaxation. The highest standards of infection control are strictly enforced. The doctors and team are constantly enhancing and advancing their technical skills, training, and education to provide patients with the highest level of quality care.

This introductory packet provides important information to help you make informed decisions about your dental care, and also gives us the information needed to provide you with the best possible dental health services. Please read the information provided and let us know if you have any questions when you come in for your first appointment.

All of us at San Elijo Dental look forward to meeting you soon, and providing you with excellent dental health services.

INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

Please read and sign if you have a PPO insurance plan. Disregard if you do not have dental insurance or have an HMO plan.

Since we feel strongly that our patients deserve the best dental care we can provide, and in an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

As a courtesy to our patients, we will submit all insurance claims on your behalf and will handle any correspondence that your insurance company may have. We ask that you pay the estimated patient portion at the time of service. If there is any residual after insurance pays, we will send that on to you for final payment.

We consider our relationship with YOU to be our primary importance and will always make our recommendations to you based on what we believe is the very best treatment for you regardless of your insurance coverage. We hope you understand that your insurance coverage is a contract between you and your insurance company, or between your employer and the insurance company. Therefore, as the patient, it is ultimately your responsibility to understand the agreement with your insurance company and/or your employer. We will assist in any way possible to maximize your dental insurance benefits.

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FACT #1: Dental Insurance is not meant to be a "PAY-ALL"; it is only meant to be an aid.

FACT #2: Many plans tell their insured that they will be covered "up to 80%" or "up to 100%". In spite of what you're told, we've found many plans down grade services and some only pay for what they call an alternate benefit. This usually consists of insurance companies paying only for the least expensive option. For example, some insurance companies pay only for amalgam fillings and not for the "upgrade" composite or tooth colored fillings. Or some insurance plans have a preexisting condition clause; this means that for certain services your insurance may not pay for treatment if it falls in to this category. The most common services that are in the category are bridges and implants if the tooth was extracted before the insurance plan was active.

FACT #3: It has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying to them that "our benefits are low". Remember you get back only what you and your employer put into your insurance coverage less the profits of the insurance company. In dealing with many dental insurance plans, most plans cover a percentage of our fees.

FACT #4: Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered, and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.

FACT #5: Insurance carriers DO NOT cover many routine dental services. We make our recommendations based on your needs and not on what your insurance may or may not cover. Please do not hesitate to ask us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. If you have any questions regarding your insurance, please contact your insurance carrier regarding the specifics and details of the plan they are operating on your behalf.

Signature: _____ Date: _____

Patient Information Form

First Name:_____ Int._____ Last Name:_____ Date of birth:_____

Home Address:_____ Apt#_____ City:_____ State:_____ Zip:_____

Cell Phone #_____ Home phone #:_____Work Phone:_____

Social Security #:_____-____-_____ Sex (M) (F) Employer:_____

In case of Emergency, Contact (Name)_____ Phone #:_____

Email Address_____

Responsible Party

(Disregard if Same as above)

First Name:_____ Int._____ Last Name:_____ Date of Birth:_____

Home Address_____ Apt#_____ City: _____ State:_____
Zip:_____

Cell Phone #:_____ Home Phone#:_____ Work phone_____

Primary Insurance Information

Insured First Name:_____ Last Name:_____ Date of Birth:_____

Patient's relationship to Insured: (circle) Self Spouse Child Parent Sex: (M) (F) Insured's Social security #: _____-_____-_____

Employer:_____ Insurance Company:_____

Policy #:_____ Group#_____ Phone #of insurance Co._____

Secondary Insurance Information

Insured First Name:_____ Last Name: _____Date of Birth:_____

Patient's relationship to Insured: (circle) Self Spouse Child Parent Sex: (M) (F) Insured's Social security #: _____-_____-_____

Employer:_____ Insurance Company:_____

Policy #:_____ Group#_____ Phone # of insurance Co._____

I request that all dental benefits, if any, otherwise payable to me for services rendered to be paid to the provider of service. I understand that I am financially responsible for all charges if insurance proceeds are insufficient to cover my obligations and/or a procedure; I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and or treatment of myself and all minor children listed by doctors, doctor's assistant and any other medical personnel. Failure to provide complete information may result in my receiving a bill for services. I am aware that by signing below I certify that all information is complete and correct. This dental office may verify this information from whichever source it deems necessary (including, but not limited to credit reports) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by the law. This is my authorization for the dental office, to verify credit history.

Signature of Patient or responsible party: _____Date:_____

MEDICAL HISTORY

Name:_____ **Date:**_____

Although dental personal primarily treat the area around your month, 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. Thank you for answering the following questions.

Primary Medical Doctors Name:_____ Phone number:_____
Are you under a physician's care now? **Yes No** If yes please explain:_____
Have you ever been hospitalized or had a major operation? **Yes No** If Yes please explain:_____
Have you ever had a serious head or neck injury? **Yes No** If Yes please explain:_____
Are you taking any medication, pills, or drugs **YES No** If yes please explain:_____

_____

Do you take, or have you taken, Phen-Fen or Redux **Yes No** Are you on a special Diet? **Yes No** Do you use tobacco? **Yes No**

Women: are you Pregnant/ trying to get pregnant? **Yes No** Nursing? **Yes No** Taking oral contraceptives? **Yes No**

Are you Allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local anesthetics

Other If yes please explain:_____

Do you have any of the following?

Yes/ No AIDS/HIIV positive	Yes/ No Chest Pains	Yes/ No frequent headaches	Yes/ No Irregular heartbeat	Yes/ No Scarlet fever
Yes/ No Alzheimer's Disease	Yes/No Cold sores	Yes/No Genital Herpes	Yes/No Kidney problems	Yes/No Shingles
Yes/No Anaphylaxis	Yes/No Congenital Heart Disorder	Yes/ No Glaucoma	Yes/ No Leukemia	Yes/ No Sickle cell Disease
Yes/No Anemia	Yes/ No convulsion	Yes/ No Hay fever	Yes/ No Liver Disease	Yes/ No Sinus trouble
Yes/ No Angina	Yes/ No Cortisone medication	**Yes/ No Heart attack/failure**	**Yes/ No Low blood pressure**	Yes/ No Spine Bifida
Yes/ No Arthritis/ gout	Yes/ No Diabetes	Yes/ No Heart murmur	Yes/ No Lung disease	Yes/ No Stomach intestinal Disease
Yes/ No Artificial Heart Valve	Yes/ No Drug addiction	Yes/ No Heart pace maker	**Yes/ No Mitral valve prolapse**	Yes/ No Stroke
Yes/ No Artificial Joint	Yes/ No Easily winded	Yes/ No Heart trouble/ Disease	Yes/ No Pain in jaw joint	Yes/ No Swelling of limbs
Yes/ No Asthma	Yes/ No Emphysema	Yes/ No Hemophilia	Yes/ No Parathyroid disease	Yes/ No Thyroid Disease
Yes/ No Blood disease	Yes/ No Epilepsy or seizures	**Yes/ No Hepatitis A**	Yes/ No Psychiatric care	Yes/ No Tonsillitis
Yes/ No Blood transfusion	**Yes/ No Excessive bleeding**	**Yes/ No Hepatitis B or C**	Yes/ No Radiation treatments	Yes/ No Tuberculosis
Yes/ No Breathing problems	Yes/ No Excessive thirst	Yes/ No Herpes	Yes/ No Recent weight loss	Yes/ No Tumors/ growths
Yes/ No Bruise easily	Yes/ No Fainting/ dizziness	**Yes/ No High Blood pressure**	Yes/ No Renal Dialysis	Yes/ No ulcers
Yes/ No Cancer	Yes/ No Frequent coughs	Yes/ No Hives or Rash	Yes/ No Rheumatic Fever	Yes/ No Venereal Disease
Yes/ No Chemotherapy	Yes/ No Frequent Diarrhea	Yes/ No Hypoglycemia	Yes/ No Rheumatism	Yes/ No Yellow Jaundice

Do you have any other serious illness not listed above? Yes/ No If Yes please explain:_____

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 _____ Date_____

Signature of Treating Dentist_____ Date_____

Patient Consent Form

X-ray

Advantages: Contributes to more complete diagnosis, revealing hidden problems, Digital x-rays used, radiation reduced by 80%

Disadvantages: Radiation exposure, original x-rays remain property of the office

Consequences of not having x-rays: incomplete exam, dental services can not be done.

Alternatives: None

Initials:_____

Cleaning and periodontal scaling

Advantages: Eliminates bacteria build-up and gum tissue inflammation, helps control or prevent periodontal disease and bad breath

Disadvantages: Teeth and gums may become sensitive, fillings and restoration may become loose

Consequences of not having treatment: gum disease, odors, tooth loss

Alternatives: None

Initials:_____

Local Anesthesia

Advantages: Avoid pain and make treatment more comfortable

Disadvantages: prolonged numbness, nerve damage and bruising. In rare cases complications may include all those

Consequences of not having treatment: Mild to severe pain during and after treatment

Alternatives: willing to accept pain during treatment

Initials: _____

I have read the above statements and have received a copy of it. I recognize the importance in informing me of benefits, risks, and options that are associated with each treatment. I understand that certain procedures may fail due to various reasons and complications can occur. I also recognize that forces and etiology that have caused tooth decay, tooth fractures or abscesses may still be active on a tooth after its been restored. Since a restored tooth is not better than what nature has given us, fractures and decay may still occur.

I herby grant authority to the dentist treating me to administer such anesthetics, analgesics, medications, diagnostic films, or to perform such procedures as may be deemed essential or advisable in diagnosis and/or treatment. I understand the use of local anesthesia entails certain risks. I also certify that the information I submitted in the medical/ health history form is true and complete. In order to receive treatment, I contract that in the event of any difference or disagreement between the attending and me, I will give the dentist the opportunity to resolve the problem. I we are unable to agree on a solution then I agree to take the issue to a reconciliation board, such as the dental society or California state consumer affairs, board of dental examiners, and agree further to accept their resolution in lieu of pursuing remedies by way of litigation. I am aware that this will help keep the cost of treatments and services as low as possible. I also understand that this agreement is binding on my heirs and all other family members. I also certify that I have received a copy of the MSDS fact sheet along with this office's notice of privacy practices.

Signature:_____ Date:_____

Witness:_____ Date:_____

Patient acknowledgement of Privacy Policies (HIPAA) and Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health insurance to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from a third party payers (Insurance companies)
- The day to day health care operations of you practices.

I have also been informed of, and given the rights to review and secure a copy of your Notice of privacy Practices, which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these request restrictions. However, if you do agree, you are the bound to comply with these restrictions. I also understand that requesting restrictions on the use of my protected health information my result in having to pay for treatment in full, as well as being responsible to bill my own insurance.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked is not affected.

Print Patient Name:_____ Relationship to Patient:_____

Signature: _____Date:_____

Patient or legal guardian

Patient Questionnaire

Please answer the following questions **Please circle which ever times are appropriate**

How often do you brush your teeth_____ when: Morning Noon Night

Do you floss?_____ when: Morning Noon Night

Do you use Mouthwash?_____ When: Morning Noon Night

Are your teeth sensitive to Hot or cold_____, Biting/Chewing (pressure)_____, Sweets_____

Other comments:_____

_____

Please answer yes or no to the following Questions:

Have you ever had any of the following?

Orthodontic treatment? Yes No

A bite plate or guard? Yes No

Periodontal treatment? Yes No

Oral surgery? Yes No

Serious injury to mouth or head? Yes No

Fill in this box; check yes if any habits apply to you.

Habits	Yes	No
Grind teeth		
Bite cheek		
Tongue Thrust		
Mouth breather		
Bulimia/ Anorexia		
Cigar/Cigarette/pipe		
Smokeless tobacco		
Bite nails		
Toothpick stimulator		
Chew gum		
Candy		
Soft Drinks		

Cosmetic Questionnaire

Answer the following if you are interested in cosmetic treatments or obtaining any information.

Are you happy with your smile?_____

Is there anything you would change?_____

Are you happy with the shade of your teeth?_____ Shade_____

Would you like have whiter teeth?_____

Have you ever whitened you teeth?_____

OFFICE SCHEDULING POLICIES

To Our Patients:

The following information about our office policies is provided for your understanding. We feel that the more you know about our policies and methods of practice, the more we can be of service to you and avoid possible misunderstandings and frustration.

When making an appointment please realize we design our schedule to offer individualized quality care for you. We need 48 hours (two working days) notice to change an appointment. This advance notice allows us to offer this valuable chair time to another patient who is in need of treatment. We realize that circumstances sometimes prevent our patients from keeping their appointment. Regretfully you will be billed **$57.75 per scheduled hour**, for the time lost.

I have read the above information.

_____ _____

Signature Date

THE FACTS ABOUT FILLINGS (Dental Board of California Publication)

I acknowledge I have received a copy of the Dental Materials Fact Sheet dated May 2004, from San Elijo Dental as required by state law.

_____ _____

Signature Date

HIPAA Privacy Notice

HIPAA Privacy Policy

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 carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY
We are required by 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.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may 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.

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 the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We may 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 another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

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, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

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

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: s explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. 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 uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS
Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: 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, and healthcare operations, and certain other activities if they are available. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Address listed below We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the address below. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, 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, 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 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

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