JEFF CHAMBERLAIN DDS, FAMILY DENTISTRY
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Welcome to our office. We appreciate the confidence you place with us to provide your dental care. To help us meet all of your dental healthcare needs, please take a few minutes to give us the following information as thoroughly as possible.

Personal Information

Today's Date: _____

Patient's Name: _____ Home Phone: _____

Home Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Sex: M F Date of Birth: _____

Mailing Address if different: _____ E-mail address: _____

City: _____ State: _____ Zip: _____ Social Security #_____

Referred to us by: _____ Minor Single Married Divorced Widowed Separated

Person to contact in case of emergency: _____ Phone: _____

Responsible Party

Name: _____ Relationship to patient: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Is this person currently a patient in our office? Yes No Work Phone: _____

Employer Information

Employer Name: _____ Occupation: _____

Employer Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

Insurance Information

Primary Dental Insurance _____ Group Name: _____ Group #: _____

Name of Insured Person: _____ Relationship of Insured Person to Patient: _____

Insured Person's: Date of Birth: _____ ID #: _____ Social Security #: _____

Employer: _____ Work Phone #: _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Secondary Dental Insurance _____ Group Name: _____ Group #: _____

Name of Insured Person: _____ Relationship to Patient: _____

Insured Person's: Date of Birth: _____ ID #: _____ Social Security #: _____

Employer: _____ Work Phone #: _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Patient Medical History

Physician_____ Office Phone_____ Date of last exam_____

1. Are you under medical treatment now? Y N
2. Have you been hospitalized for any surgery or serious illness in the last 5 years? Please explain _____ Y N
   _____
3. Are you taking any prescription medication? Y N
   Please list: _____
   _____
   _____
4. Have you ever taken medication for cancer or osteoporosis containing Bisphosphonates such as Fosamax, Boniva, Actonel or others? Y N
5. Do you smoke or chew tobacco? Y N
6. Do you use controlled substances Y N
8. Are you wearing contact lenses? Y N
9. Are you allergic to or ever had any reactions to any of the following?
   - Local Anesthetics..... Y N
   - Penicillin or other Antibiotics..... Y N
   - Sulfa Drugs..... Y N
   - Barbiturates..... Y N
   - Sedatives..... Y N
   - Iodine..... Y N
   - Aspirin..... Y N
   - Metals..... Y N
   - Latex rubber..... Y N
   - Other (please list) _____
10. Women only
    - Are you pregnant or think you may be? Y N
    - Are you nursing? Y N
    - Are you taking oral contraceptives? Y N

7. Do you have or have you ever had any of the following?

High Blood Pressure	Y N	Heart Disease	Y N	Chest Pains	Y N
Heart Attack	Y N	Cardiac Pacemaker	Y N	Easily Winded	Y N
Rheumatic Fever	Y N	Heart Murmur	Y N	Stroke	Y N
Swollen Ankles	Y N	Angina	Y N	Hay Fever	Y N
Fainting / Seizures	Y N	Frequently Tired	Y N	Tuberculosis	Y N
Asthma	Y N	Anemia	Y N	Radiation Therapy	Y N
Low Blood Pressure	Y N	Emphysema	Y N	Glaucoma	Y N
Epilepsy / Convulsions	Y N	Cancer	Y N	Recent Weight Loss	Y N
Leukemia	Y N	Arthritis	Y N	Liver Disease	Y N
Diabetes	Y N	Joint Replacement	Y N	Heart Trouble	Y N
Kidney Disease	Y N	Hepatitis / Jaundice	Y N	Respiratory Problems	Y N
AIDS or HIV	Y N	Thyroid Problem	Y N	Stomach Issues / Ulcer	Y N
Sexually Transmitted Dis.	Y N	Mitral Valve Prolapse	Y N	Other_____	Y N

8. Comments_____
_____
_____
_____
_____
_____
_____

Patient Dental History

Name of Previous Dentist _____ Location _____ Date Last Seen _____

1. Why have you come in today? _____
2. How would you describe your current dental health? _____
3. Do your gums bleed when you brush of floss? Y N
4. Are any of your teeth sensitive to hot or cold? Y N
5. Do you have any pain in any of your teeth? Y N
6. Do you have any lumps or sores in or near your mouth? Y N
7. Have you had any head, neck or jaw injuries? Y N
8. Have you ever experienced any of the following problems with your jaw?
    a. Clicking in joint Y N
    b. Pain in joint Y N
    c. Pain in ear Y N
    d. Pain in side of face Y N
    e. Difficulty in opening or closing Y N
    f. Difficulty in chewing Y N
9. Do you have frequent headaches? Y N
10. Do you clench or grind your teeth? Y N
11. Have you had any problems with previous dental treatment? Y N
12. Have you had any difficult extractions in the past? Y N
13. Have you ever had prolonged bleeding following extractions? Y N
14. Have you had orthodontic treatment? Y N
15. Do you wear full dentures or partial dentures? Y N
    When were they made? _____
16. Do you have any issues with the appearance of your teeth Y N
    That you would like to discuss?

_____
_____
_____
_____
_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I also understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent/guardian if patient is a minor) Date

FINANCIAL POLICIES AND OPTIONS

Jeff Chamberlain DDS

Family Dentistry

For your convenience, we have several financial options available for the dental care you will be receiving:

DENTAL INSURANCE

Your dental insurance is a contract between you and your insurance company, not between your insurance company and the dentist. You are still the responsible party regarding your account. We will be happy to process your insurance forms at no charge.

Most insurance companies do not cover 100% of all dental expenses. Please be aware that we are only capable of **estimating** your portion, since each insurance company has their own specific limitations and exclusions.

CASH, CHECK OR DEBIT CARD

For those without dental insurance, we offer a 10% discount for payment in full using cash, check or debit card at the time your services are performed.

CREDIT CARD

For those without dental insurance, we offer a 5% discount for payment in full if you pay by MasterCard, Visa, Discover Card or American Express at the time your services are performed.

CARECREDIT

We are contracted with a credit card company called CareCredit that will finance your dental treatment with approved credit. This will allow you to complete your dental work without delay and make reasonable monthly payments to CareCredit. Ask at the front desk for details.

GRADUAL TREATMENT PLAN

In some cases it may be helpful for patients to spread treatment out over a longer period of time in order to keep your account balance at a more comfortable level for you. We can help you decide what treatment must be done first and what can be allowed to wait.

_____ _____

Responsible Party's Signature Date

Jeff Chamberlain DDS

Acknowledgement of Receipt of Notice of Privacy Practices

By signing, I am stating that I have received a copy of this office's Notice of Privacy Practices:

Print Name of Patient_____

Signature of Patient or Patient's Representative_____

Relationship to Patient (If not signed by Patient) _____

Date_____

For Office Use Only:

An attempt to obtain written acknowledgement of Receipt of our Notice of Privacy Practices was attempted, however acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other _____

_____

_____

Health Information Disclosure to Family and Friends Authorization

I authorize the disclosure of my health information to a family member, friend or other person to the extent necessary to help with my healthcare or with payment for my healthcare as listed below. I understand that I may revoke this authorization at any time in writing. My revocation will not affect any use or disclosures permitted by my authorization while it was in effect.

Person(s) I authorize: (Please Print)

1 - _____ Relationship: _____

2 - _____ Relationship: _____

3 - _____ Relationship: _____

Signature _____

JEFF CHAMBERLAIN DDS

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 February 1st, 2015 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the 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 the Notice, please contact us using the information listed at the end of the 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 a 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 or 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 use or disclosure of PHI for marketing and for the sale of PHI. We will also obtain your written authorization before using or disclosing you PHI for purposes other than those provided for in the 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 of 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-basis 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.

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 you 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 request. 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 Website or by email.

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, 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 upon request.

Our Privacy Official:	**Jeff Chamberlain**
Telephone:	**530-577-8080**
Address:	**3170 US Highway 50, Suite 3, South Lake Tahoe, CA 96150**
Email:	**jcdds@att.net**