



PATIENT PACKET

Southwest Dental Group
1502 S. La Brucherie Road
El Centro, CA 92243

Melissa Mani, D.D.S.

Phone: 760-482-5505
Fax: 760-482-5501
www.swestdentalgroup.com

Welcome to Southwest Dental Group.

PATIENT INFORMATION:

Informacion del paciente

Patient Name: _____ DOB: _____
Nombre del Paciente Fecha de Nacimiento

Soc Sec #: _____ Sex: M F Marital Status: _____
Numero de Seguro Social Sexo estado civil

Address: _____
Domicilio (street number & name) city zip code

Phone: (_____) _____ Cell Phone: (_____) _____
Numero de Telefono Numero de Celular

** IF PATIENT IS A MINOR, please fill out the *following section* with **YOUR** information.
** Si el paciente es menor de edad, favor de *llenar la siguiente seccion* con **SU** informacion.

RESPONSIBLE PARTY:

Patient Name: _____ DOB: _____
Nombre del Paciente Fecha de Nacimiento

Soc Sec #: _____ Sex: M F Marital Status: _____
Numero de Seguro Social Sexo estado civil

Address: _____
Domicilio (street number & name) city zip code

Phone: (_____) _____ Cell Phone: (_____) _____
Numero de Telefono Numero de Celular

Employer: _____ Phone: (_____) _____
Trabajo Numero de Telefono

1st INSURANCE:

Subscriber's Name: _____ DOB: _____
Nombre del asegurado fecha de nacimiento

Soc Sec #: _____ Employer: _____
Numero de seguro social trabajo

Insurance: _____ ID or Group #: _____
Aseguranza

2nd INSURANCE:

Subscriber's Name: _____ DOB: _____
Nombre del asegurado fecha de nacimiento

Soc Sec #: _____ Employer: _____
Numero de seguro social trabajo

Insurance: _____ ID or Group #: _____
Aseguranza

How did you hear from us? circle one

Website Search (Google or Yahoo) Q96 Radio TV Ads Newspaper Yellowpages Other _____

Email: _____

Emergency contact: _____ **Phone #:** _____

Patient's Name: _____

Date: _____

Although dental personnel primarily treat the area in and around your mouth, 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:

Are you under a physician's care now?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please explain: _____
Have you ever been hospitalized or had major operation?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please explain: _____
Are you taking medications, pills, or drugs?	<input type="radio"/> Yes	<input type="radio"/> No	If yes, please explain: _____
Do you take, or have taken, Phen-Fen or Redux?	<input type="radio"/> Yes	<input type="radio"/> No	_____
Are you on a special diet?	<input type="radio"/> Yes	<input type="radio"/> No	_____
Do you use tobacco?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you use controlled substances?	<input type="radio"/> Yes	<input type="radio"/> No	

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? 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, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives/Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spinal Bifida	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stoke	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorders	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatment	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any 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/Guardian: _____ Date: _____

Reviewed by (doctor's signature): _____ Date: _____



SOUTHWEST DENTAL GROUP

1502 S La Brucherie Road
El Centro, CA 92243

Melissa Mani, D.D.S

Ph: 760.482.5505

Fax: 760.482.5501

www.swestdentalgroup.com

OFFICE POLICIES/ POLIZAS

In an effort to avoid misunderstandings and to keep billing costs a minimum, we are presenting you with a statement of our policies concerning payment of your account and the processing of your insurance forms.

Para evitar mal entendidos y reducir costos, nuestra oficina ha implementado lo siguiente referente a su cuenta y el procedimiento de cobrar a su aseguranza.

INSURANCE/ ASEGURANZA

This office is happy to cooperate with the patients who are covered by insurance. Please read your policy to be sure that you are fully aware of any limitations of benefits provided. It is important to understand that, in most cases, insurances are designed to reduce your costs, not eliminate completely. At the time of service, you will be asked to pay your percentage for routine dental work. You are ultimately responsible for the full amount of your bill, regardless of insurance coverage, as we are not a party to your insurance contract.

Es importante entender que las aseguranzas son formadas para reducir el costo de su bolsillo, no eliminar el costo total. Lea su poliza para asegurarse de los beneficios y limitaciones. Al tiempo de su visita, sera requisito pagar el porcentaje de su tratamiento dental. Usted es responsable por el total de su cuenta, sin importar su cobertura.

APPOINTMENTS/ CITAS

We will be as flexible as possible to meet your needs in scheduling appointments. Please give us 24 hours notice if you plan to cancel an appointment. If our office is not notified of cancellation, a \$25 charge will be applied to your account. Please honor your appointments!

Haremos lo posible por citarles a su conveniencia. Favor de notificarnos con 24 horas de anticipacion si piensa en cancelar su cita. Si no, se le agregara un cobro de \$25 a su cuenta. Favor de asistir a sus citas!

FINANCIAL ARRANGEMENTS/ARREGLOS FINANCIEROS

Payment is expected at the time of treatment. This office accepts Visa, Mastercard, Discover, American Express, personal checks or cash. For your convenience, we offer a healthcare credit line – please inquire at front desk. If an account is turned over for collection, a 20% fee will be applied, plus interest at attorney fees. Any checks returned from the bank are subject to an additional \$25 fee to cover costs charged by the bank.

Pago se requiere al tiempo de su visita. Aceptamos Visa, Mastercard, American Express, cheques personales o effective. Para su conveniencia, ofrecemos una linea de credito – favor de informarse con la recepcionista. Si su cuenta se manda a coleccion, se le aplicara un cargo de 20% mas intereses y cargos de abogado. Para cheques sin fondos, se aplicara un cargo de \$25 para cubrir costos del banco.

I have read the above policy and agree to accept financial responsibility for my bills as outlined in the policy. I authorize the release of any information required to submit my dental claim(s).

He leído y entendido lo anterior, y acepto responsabilidad de mi cuenta como delineado. Autorizo dar informacion necesaria para mandar cobrar a mi aseguranza.

Patient Name/ Nombre del Paciente: _____

Signature/Firma: _____ Date/Fecha: _____

CONSENT TO THE USE AND DISCLOSURE OF THE HEALTH INFORMATION FOR THE TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

Patient Name: _____

Birth Date: _____ **Social Security:** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party-payer can verify that services billed were actually provided.
- A tool or routine healthcare options such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for director purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions required.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health:

I acknowledge that I have received a copy of the organization's Notice of Privacy Practices for Protected Health Information (PHI) under HIPPA.

Patient Name: _____ **Date:** _____

Signature: _____

Description of personal representative's authority to act for the patient.

OFFICE USE ONLY:

- Accepted
- Denied

Signature

Title

Date

NOTICE OF PRIVACY PRACTICES (DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, penalties for covered entities that misuse personal health information.

As required by "HIPPA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations:

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An *example* of this would include teeth cleaning services.
- **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An *example* of this would be sending a bill for your visit to your insurance company for payment.
- **HEALTH CARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An *example* would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer:

The right to request restrictions certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us UPON REQUEST.

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. (previous page)

Name: _____ Birthdate: _____

Signature: _____

Date: _____