



## PATIENT PACKET

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

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[www.swestdentalgroup.com](http://www.swestdentalgroup.com)

# Patient Information

Patient Full Name: \_\_\_\_\_

Nombre del Paciente

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Fecha de Nacimiento

Soc Sec #: \_\_\_\_\_

Numero de Seguro Social

Sex: M F

Sexo

Marital Status: \_\_\_\_\_

Estado Civil

Address: \_\_\_\_\_

Domicilio street/calle

city/ciudad

zip code/codigo postal

Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Numero de Telefono

Numero de Celular

Correo Electronico

Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Trabajo

Numero de Telefono

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Contacto de Emergencia

Numero de Telefono

\*\*\*How did your hear about us? / Como escucho de la oficina? \*\*\* (Please circle one)

KXO Radio

ADS

Newspaper

Phonebook

Power98 Radio

Other: \_\_\_\_\_

**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:**

(Persona Responsable)

Relationship to Patient: \_\_\_\_\_

Relacion con el Paciente

Full Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Nombre

Fecha de Nacimiento

Soc Sec #: \_\_\_\_\_

Numero de Seguro Social

Sex: M F

Sexo

Marital Status: \_\_\_\_\_

Estado Civil

Address: \_\_\_\_\_

Domicilio street/calle

city/ciudad

zip code/codigo postal

Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Numero de Telefono

Numero de Celular

Correo Electronico

Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Trabajo

Numero de Telefono

## **Primary Insurance Information:** (Informacion sobre Su Seguro Principal)

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Nombre del asegurado

fecha de nacimiento

Soc Sec #: \_\_\_\_\_ Employer: \_\_\_\_\_

Numero de seguro social

trabajo

Insurance: \_\_\_\_\_ ID or Group: \_\_\_\_\_

Aseguranza

## **Secondary Insurance Information:** (Informacion sobre el Seguro Adicional)

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Nombre del asegurado

fecha de nacimiento

Soc Sec #: \_\_\_\_\_ Employer: \_\_\_\_\_

Numero de seguro social

trabajo

Insurance: \_\_\_\_\_ ID or Group: \_\_\_\_\_

Aseguranza

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



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## OFFICE POLICIES / POLIZAS

In an effort to avoid misunderstandings and to keep billing costs to 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 them 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 notify us within 24 hours 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 hay notificacion, se le agregara un cobro de \$25 a su cuenta. Favor de asistir a sus citas!*

### X-RAYS AND RECORDS / RADIOGRAFIAS E INFORMACION DE TRATAMIENTO DENTAL

In our office, we strive to meet our patient's needs and understand the importance of being prompt. Please allow us 8 working days to provide you with any x-rays or records that you request. The patient or parent (if patient is a minor) is required to sign a Dental Release Form before x-rays/records are provided. There will be a \$25 fee for x-rays or a \$75 fee for records, collected at the time The Dental Release Form is signed.

*En nuestra oficina entendemos la importancia de ser puntual y reconocemos sus necesidades. Le pedimos al paciente 8 dias laborales para la entrega de radiografias/informacion de tratamiento dental que usted requiere. El paciente a padre (en caso de ser menor de edad) necesita firmar la forma de consentimiento antes de la entrega de radiografias y/o informacion de tratamiento dental. Hay un cargo de \$25 por radiografias y \$75 por la informacion de su tratamiento dental, que sera cobrado al firmar la forma de consentimiento.*

### 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. Any checks returned from the bank are subject to an additional \$25 fee to cover costs charged by bank. Balances over 30 days are subject to finance charges. If an account is turned over to collections, a 20% fee will be applied, plus interest and attorney fees.

*Pago se requiere al tiempo de su visita. Aceptamos Visa, Mastercard, Discover, American Express, cheques personales o efectivo. Para su conveniencia, ofrecemos una linea de credito – favor de informarse con la recepcionista. Para cheques sin fondos, se aplicara un cargo de \$25 para cubrir costos del banco. Balances que sobrepasen 30 dias estan sujetos a cargos financieros. Si su cuenta se manda a coleccion, se le aplicara un cargo de 20% mas intereses y cargos de abogado.*

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

*He leído lo anterior y acepto la 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: \_\_\_\_\_

PATIENTS NAME:

DATE OF EXAMINATION:

	EXISTING		PATHOLOGY		OPTIONAL
1		1		1	
2		2		2	
3		3		3	
4 A		4 A		4 A	
5 B		5 B		5 B	
6 C		6 C		6 C	
7 D		7 D		7 D	
8 E		8 E		8 E	
9 F		9 F		9 F	
10 G		10 G		10 G	
11 H		11 H		11 H	
12 I		12 I		12 I	
13 J		13 J		13 J	
14		14		14	
15		15		15	
16		16		16	
17		17		17	
18		18		18	
19		19		19	
20 K		20 K		20 K	
21 L		21 L		21 L	
22 M		22 M		22 M	
23 N		23 N		23 N	
24 O		24 O		24 O	
25 P		25 P		25 P	
26 Q		26 Q		26 Q	
27 R		27 R		27 R	
28 S		28 S		28 S	
29 T		29 T		29 T	
30		30		30	
31		31		31	
32		32		32	
PROPHY		PROPHY		PROPHY	
LIGHT SCALE		LIGHT SCALE		LIGHT SCALE	
SRP		SRP		SRP	
PUD		PUD		PUD	
PLD		PLD		PLD	
FUD		FUD		FUD	
FLD		FLD		FLD	

**1) HEAD AND NECK EXAMINATION:**

	NORMAL	ABNORMAL
FACE	<input type="checkbox"/>	<input type="checkbox"/>
CERVICAL AREAS	<input type="checkbox"/>	<input type="checkbox"/>
ORAL MUCOSA	<input type="checkbox"/>	<input type="checkbox"/>
TONGUE	<input type="checkbox"/>	<input type="checkbox"/>
FLOOR OF MOUTH	<input type="checkbox"/>	<input type="checkbox"/>
THROAT	<input type="checkbox"/>	<input type="checkbox"/>
PALLATE	<input type="checkbox"/>	<input type="checkbox"/>
BRUXISM	<input type="checkbox"/>	<input type="checkbox"/>

**2) RADIOGRAPHIC:**

ABNORMALITIES: \_\_\_\_\_  
 BONE LEVEL: \_\_\_\_\_

**3) CLINICAL IMPRESSIONS/DIAGNOSIS:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

