PATIENT REGISTRATION AND HEALTH HISTORY

1. GETTING TO KNOW YOU

DATE: **REFERRING DR.:**

NAME OF PATIENT (PLEASE PRINT):

WHAT WOULD YOU LIKE US TO CALL YOU?

GUARDIAN ☐ **OR SPOUSE** ☐ **NAME:**

ADDRESS:

CITY: **STATE:** **ZIP:**

HOME PHONE NUMBER: ( ) **CELL PHONE NUMBER: ( )**

EMAIL ADDRESS:

BIRTHDATE: **AGE:** **MALE** ☐ **FEMALE** ☐

SOCIAL SECURITY NUMBER (PLEASE PROVIDE):

EMPLOYER: **BUSINESS TELEPHONE:**

SCHOOL (IF PATIENT IS CHILD): **GRADE:**

IF YOUR CHILD'S ADDRESS IS NOT THE SAME AS YOURS, PLEASE ENTER YOUR ADDRESS BELOW:

2. INSURANCE COVERAGE

1) PRIMARY INSURANCE COMPANY:

EMPLOYEE / SUBSCRIBER NAME:

SUBSCRIBER ID # (OR SOCIAL SEC.#): **DATE OF BIRTH:**

GROUP NUMBER:

EMPLOYER:

2) SECONDARY INSURANCE COMPANY (IFAPPLICABLE):

EMPLOYEE / SUBSCRIBER NAME:

SUBSCRIBER ID # (OR SOCIAL SEC.#): **DATE OF BIRTH:**

GROUP NUMBER:

EMPLOYER:

3. EMERGENCY CONTACT

IS THERE ANOTHER RELATIVE WHO IS A PATIENT AT THIS OFFICE?

1) PERSON TO CONTACT IN CASE OF AN EMERGENCY (RELATIVE):

PHONE NUMBER:

ADDRESS:

2) PERSON TO CONTACT IN CASE OF AN EMERGENCY:

PHONE NUMBER:

ADDRESS:

4. ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (NAME):

RELATIONSHIP TO PATIENT:

DRIVER'S LICENSE #:

PLEASE INDICATE WHICH OF THE FOLLOWNG YOU HAVE EXPERIENCED: Check (✓) "yes" or "no" to each item.

	YES	NO
Heart Failure	☐	☐
Heart Disease or Attack	☐	☐
Angina Pectoris	☐	☐
Congenital Heart Disease	☐	☐
Heart Murmur	☐	☐
High Blood Pressure	☐	☐
Arteriosclerosis	☐	☐
Mitral Valve Prolapse	☐	☐
Artificial Heart Valve	☐	☐
Heart Pacemaker	☐	☐
Heart Surgery	☐	☐
Rheumatic Fever	☐	☐
Hearing Impairment	☐	☐
Arthritis	☐	☐
Rheumatism	☐	☐
Pain in Jaw Joints	☐	☐
Cortisone Medicine	☐	☐
Drug Addiction	☐	☐
Premedicate Prior to Dental Visits	☐	☐

	YES	NO
Stroke	☐	☐
Artificial Joints (hip, knee, etc)	☐	☐
Kidney Trouble	☐	☐
Ulcers	☐	☐
Diabetes	☐	☐
Thyroid Problems	☐	☐
Immune Deficiency	☐	☐
Glaucoma	☐	☐
Cosmetic Surgery	☐	☐
Emphysema	☐	☐
Chronic Cough	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Hay Fever	☐	☐
Allergies or Hives	☐	☐
Sinus Trouble	☐	☐
Radiation Therapy	☐	☐
Chemotherapy	☐	☐
Dental Phobia	☐	☐

	YES	NO
Hepatitis A (infectious)	☐	☐
Hepatitis B (serum)	☐	☐
Hepatitis C (infection)	☐	☐
Venereal Disease	☐	☐
A.I.D.S.	☐	☐
H.I.V. Positive	☐	☐
Cold Sores/Fever Blisters	☐	☐
Blood Transfusion	☐	☐
Hemophilia	☐	☐
Anemia	☐	☐
Sickle Cell Disease	☐	☐
Bruise Easily	☐	☐
Liver Disease	☐	☐
Yellow Jaundice	☐	☐
Epilepsy or Seizures	☐	☐
Fainting or Dizzy Spells	☐	☐
Nervousness	☐	☐
Latex Allergy	☐	☐
Psychiatric Treatment	☐	☐

1. Are you having pain or discomfort at this time? ………… YES NO
2. Have you been a patient in the hospital in the past two years? ………… YES NO
3. Have you been under the care of a doctor in the past two years? ………… YES NO
   Physician's Name ____________________
   Address ____________________ Telephone ____________
4. Have you taken any medication or drugs in the past two years? ………… YES NO
5. Are you taking any medication, drugs, or pills? ………… YES NO
   If yes, please list ____________________
6. Are you aware of being allergic to or have you ever acted adversely to any medication or substance? ………… YES NO
   If yes, please list ____________________
8. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ………… YES NO
9. Do your ankles swell during the day? ………… YES NO
10. Do you use more than two pillows to sleep? ………… YES NO
11. Have you lost or gained more than 10 pounds in the past year? ………… YES NO
12. Do you ever wake up from sleep and feel short of breath? ………… YES NO
13. Are you on a special diet? (Fen Phen) ………… YES NO
14. Has your medical doctor ever said you have cancer or a tumor? ………… YES NO
15. Do you have or have you had any disease, condition, or problem not listed? ………… YES NO
    If yes, please list ____________________

FOR WOMEN ONLY:

Are you pregnant? ☐Yes ☐No If yes, what month? ____ Are you nursing? ☐Yes ☐No

Are you taking birth control pills? ☐Yes ☐No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Patient Signature ____________________ Date ____________

CONSENT:

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with (name of Patient) ____________________ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time the services are rendered unless financial arrangements have been made. I further understand a 1 1/2 % finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note.

Patient/Guardian Signature ____________________ Date ____________

REGISTRO DEL PACIENTE E HISTORIA DE LA SALUD

1. CONOCER A USTED

FECHA: DR QUE SE REFERÍO.:

NOMBRE DEL PACIENTE:

¿QUE LÉ GUSTARÍA QUE LE LLAMEMOS?

NOMBRE DEL ☐GUARDIÁN O ☐CÓNYUGE:

DIRECCIÓN:

CIUDAD: ESTADO: CÓDIGO POSTAL:

INICIO NÚMERO DE TELÉFONO: ( ) NÚMERO DE TELÉFONO CELULAR: ( )

DIRECCIÓN DE CORREO ELECTRÓNICO:

FECHA DE NACIMIENTO: EDAD: MACHO ☐ HEMBRA ☐

NÚMERO DE SEGURO SOCIAL (INDICAR):

EMPLEADOR: TELEFONO DE NEGOCIO:

ESCUELA (SI EL PACIENTE ES NIÑO): GRADO:

SI LA DIRECCIÓN DEL SU HIJO NO ES IGUAL QUE EL SUYO, INTRODUZCA SU DIRECCIÓN DE ABAJO:

2. COBERTURA DE SEGURO

1) PRIMARIA COMPAÑÍA DE SEGUROS:

EMPLEADO/ NOMBRE DEL SUSCRIPTOR: FECHA DE NACIMIENTO:

IDENTIFICACIÓN DE SUSCRIPTOR # (O # DE SEGURO SOCIAL):

NÚMERO DE GRUPO:

EMPLEADOR:

2) SECUNDARIA COMPAÑÍA DE SEGUROS (SI ES APICABLE):

EMPLEADO/ NOMBRE DEL SUSCRIPTOR: FECHA DE NACIMIENTO:

IDENTIFICACIÓN DE SUSCRIPTOR # (O # DE SEGURO SOCIAL):

NÚMERO DE GRUPO:

EMPLEADOR:

3. CONTACTO DE EMERGENCIA

¿HAY OTRO FAMILIAR QUE ES UN PACIENTE EN ESTA OFICINA?

1) PERSONA DE CONTACTO EN CASO DE EMERGENCIA (RELATIVA):

NÚMERO DE TELÉFONO:

DIRECCIÓN:

2) PERSONA DE CONTACTO EN CASO DE EMERGENCIA:

NÚMERO DE TELÉFONO:

DIRECCIÓN:

4. INFORMACIÓN DE CUENTA

RESPONSIBLE FINANCIERO PARA ESTA CUENTA (NOMBRE):

RELACIÓN CON EL PACIENTE:

LICENCIA DE CONDUCIR #:

POR FAVOR INDIQUE CUÁLES DE LOS SIGUIENTES USTED HA EXPERIMENTADO: Marque (✓) "sí" o "no" a cada elemento.

	SÍ	NO
La insuficiencia cardíaca	☐	☐
Enfermedad cardiaca o ataque....	☐	☐
Angina de pecho.................	☐	☐
Cardiopatía congénita...........	☐	☐
Soplo cardíaco..................	☐	☐
Alta presion sanguinea..........	☐	☐
Arteriosclerosis................	☐	☐
Prolapso de la válvula mitral....	☐	☐
Válvula Artificial del Corazón....	☐	☐
Marcapasos cardíaco.............	☐	☐
Cirugía de corazón..............	☐	☐
Fiebre reumática................	☐	☐
La discapacidad auditiva	☐	☐
Artritis........................	☐	☐
Reumatismo......................	☐	☐
El dolor en la mandíbula articulaciones..	☐	☐
La cortisona Medicina	☐	☐
Drogadicción....................	☐	☐
Premedicación antes de las visitas dentales..	☐	☐

	SÍ	NO
Accidente cerebrovascular.........	☐	☐
Las articulaciones artificiales.....	☐	☐
Problema de riñón	☐	☐
Úlceras...........................	☐	☐
Diabetes	☐	☐
Problemas tiroideos...............	☐	☐
Inmunodeficiencia.................	☐	☐
Glaucoma..........................	☐	☐
Cirugía cosmética.................	☐	☐
Enfisema..........................	☐	☐
Tos crónica.......................	☐	☐
Tuberculosis......................	☐	☐
Asma..............................	☐	☐
Fiebre de heno....................	☐	☐
Alergias o urticaria	☐	☐
Sinusitis	☐	☐
Terapia de radiación..............	☐	☐
Quimioterapia.....................	☐	☐
Fobia dental	☐	☐

	SÍ	NO
La hepatitis A (infecciosa)	☐	☐
La hepatitis B (suero).	☐	☐
La hepatitis C (infección)	☐	☐
Enfermedad venérea..................	☐	☐
SIDA	☐	☐
VIH Positivo	☐	☐
El herpes labial	☐	☐
Transfusión de sangre...............	☐	☐
Hemofilia............................	☐	☐
Anemia...............................	☐	☐
Enfermedad de célula falciforme.	☐	☐
Fácilmente moretón	☐	☐
Enfermedad del higado...............	☐	☐
La ictericia amarilla	☐	☐
Epilepsia o convulsiones	☐	☐
Desmayos o mareos	☐	☐
Nerviosismo..........................	☐	☐
Alergia al latex.....................	☐	☐
Tratamiento psiquiatrico............	☐	☐

1. ¿Está teniendo dolor o malestar en este momento? .... SÍ NO
2. ¿Ha sido un paciente en el hospital en los últimos dos años? .... SÍ NO
3. ¿Ha estado bajo el cuidado de un médico en los últimos dos años? .... SÍ NO
   Nombre del medico ______________________________
   Dirección ______________________________ Teléfono ______________
4. ¿Ha tomado alguna medicación o drogas en los últimos dos años? .... SÍ NO
5. ¿Está tomando medicación, drogas o pastillas? .... SÍ NO
   En caso afirmativo, enumere______________________________
6. ¿Está usted consciente de ser alérgica a la o lo ha actuado de manera adversa a algún medicamento o sustancia? .... SI NO
   En caso afirmativo, enumere ______________________________
7. Cuando subes o dar un paseo, ¿alguna vez tiene que parar debido a un dolor en el pecho, falta de aliento, o porque se está muy cansado?. SÍ NO
8. ¿Sus tobillos se hinchan durante el día? .... SÍ NO
9. ¿Utiliza más de dos almohadas para dormir? .... SÍ NO
10. ¿Ha ganado o perdido más de 10 libras en el último año? .... SÍ NO
11. ¿Alguna vez se despierta del sueño y la sensación de falta de aliento? .... SÍ NO
12. ¿Está usted en una dieta especial? (Fen Phen) .... SÍ NO
13. ¿Su médico ha dicho alguna vez que tiene cáncer o un tumor? .... SÍ NO
14. ¿Tiene o ha tenido alguna enfermedad, condición o problema no aparece arriba? .... SÍ NO
    En caso afirmativo, enumere ______________________________

SÓLO PARA MUJERES

- ¿Estas embarazada? ☐Sí ☐No En caso afirmativo, en qué mes? ______
- ¿Está amamantando? ☐Sí ☐No
- ¿Está tomando píldoras anticonceptivas? ☐Sí ☐No

Entiendo la información anterior es necesario proveer de mí el cuidado dental de una manera segura y eficiente. Respondí todas las preguntas con la verdad y con lo mejor de mi conocimiento.

Firma del paciente ______________________________Date______________

CONSENTIMIENTO:

El Herby firmante autoriza médico tomar rayos X, los modelos de estudio, fotografías, o cualesquiera otros medios de diagnóstico consideren apropiadas por el doctor para hacer un diagnóstico exhaustivo de las necesidades dentales del paciente. También autorizo médico para realizar cualquiera y todas las formas de tratamiento, la medicación y la terapia, que puede estar indicado en relación con (nombre del paciente) ______________________ y, además autorizar y consentimiento de que el doctor elegir y emplear cualquier asistencia según sea necesario. También entiendo el uso de agentes anestésicos encarna un cierto riesgo. Yo entiendo que la responsabilidad del pago por los servicios dentales proporcionados en esta oficina para mí o mis dependientes es mío, exigible en el momento los servicios se prestan menos que se hayan hecho arreglos financieros. Además, entiendo un cargo financiero 1 1/2% (18% anual) se añadirá a cualquier saldo de más de 60 días. En el caso de incumplimiento I (nos) comprometo a pagar los intereses legales sobre el endeudamiento, junto con los costes de recogida y honorarios de abogado razonables que puedan ser necesarios para afectar colección de esta nota.

Firma del Paciente / Tutor ______________________________ ______________________________ Date______________

Name:____

(Last) (First) (MI)

Brief Explanation of Dental Symptoms:____

____

____

Directions: Please circle *Yes* or *No* to the following questions.

Yes	**No**	Do you know what tooth/teeth/ area that you have been referred here for? If Yes, please specify:____
Yes	**No**	I have or had pain or sensitivity. **If Yes:** **1.** The level of pain that I have or had on a scale of 0 to 10? Usually ____at its worst____, right now____. **2.** I first noticed the pain _____days _____weeks _____months ago **3.** The pain occurs when I _____ bite down, _____ lie down or eat foods/liquids that are ____hot ____cold ____sweet. **4.** Duration of pain: ___comes and goes, ____lingers for ____ seconds, ____ minutes or ____hours or it is ___constant.
Yes	**No**	Are you taking pain medication? If yes what?____________________________________
Yes	**No**	Are you taking antibiotics? If yes what?____ When did you start the antibiotics?____
Yes	**No**	Do you have swelling? **If Yes:** I ___have or had a gum boil, ____swelling around the tooth or swelling around ____the lip, ____chin, ____cheek, ____ jaw on the involved side.
Yes	**No**	Do you have numbness? **If Yes:** I have numbness on my ____gum, ____lip, ____chin, ____jaw of the involved side.
Yes	**No**	Have you had dental work done on this tooth? **If Yes:** What and when? ____ gum surgery, ____braces, ____root canal, ____filling, ____crown, ____bite adjustment. When?__________________________
Yes	**No**	Did you have an accident involving this tooth? **If Yes:** What and when?____________________
Yes	**No**	Does your tooth feel loose?
Yes	**No**	Does your nose feel stuffy or do you feel like you may have a cold? **If Yes:** When did your symptoms start?_________________________
Yes	**No**	Do you clench, grind or wear a night guard?
Yes	**No**	Do you have pain in your jaw joints (TMJ), jaw pops or clicks, or trouble opening or closing your mouth.
Yes	**No**	Do you go to your dentist regularly? My past dental care: ___ regular visit, ___occasional check up or ____emergency visit only.
Yes	**No**	Do you have anxiety when you go to the dentist? **If Yes:** ___somewhat apprehensive, ___ moderate anxiety, ____severe anxiety.
Yes	**No**	Does it generally take you longer to get numb?

Patient/ Guardian Signature:_______________________________________ **Date:**______________________

** (For office use only.) **

Notes:____

____

Nombre: ____
(Apellido) (Nombre)

Breve explicación de los síntomas dentales: ____

____

____

Instrucciones: Por favor marque Sí o No a las siguientes preguntas.

Sí	No	
Sí	**No**	¿Sabes para qué diente / área te dieron una referencia? En caso afirmativo, especificar:______________________________
Sí	**No**	Me tiene o ha tenido dolor o sensibilidad. En caso afirmativo: **1.** El nivel de dolor que tengo o he tenido en una escala de 0-10? Generalmente (nivel #) _____, en su peor _____, ahora mismo_____. **2.** Noté el dolor por primera vez hace _____ días / semanas / meses **3.** El dolor se produce cuando (marque): ____ muerdo, _____ me acuesto o como comida / líquidos que están ____ calientes ____ fríos ____ dulces. **4.** La duración del dolor: ___ va y viene, ___ permanece durante para # ____ segundos/minutos/horas o ___ es constante.
Sí	**No**	¿Está tomando medicamentos para el dolor? Si es así, ¿qué? ______________________________
Sí	**No**	¿Está tomando antibióticos? Si es así, ¿qué? ______________________________ ¿Cuándo comenzó a los antibióticos? ______________________________
Sí	**No**	¿Tiene la hinchazón? En caso afirmativo (marque): Tengo o tenia: ___ una ebullición de las encías, ____ hinchazón alrededor del diente, o hinchazón alrededor de ___ el labio, ___ mentón, ___ mejilla, ___ mandíbula en el lado afectado.
Sí	**No**	¿Tiene entumecimiento? En caso afirmativo (marque): Tengo entumecimiento en mi: ___ encía, ___ labio, ___ mentón, ___ mandíbula en el lado afectado.
Sí	**No**	¿Ha tenido trabajo dental en este diente? En caso afirmativo (marque): ___ cirugía de las encías, ___ aparatos ortopédicos, ___ tratamiento de conducto radicular root, ___ relleno, ___ corona, ___ el ajuste de mordida crown. ¿Cuando? ______________________________
Sí	**No**	¿Tuvo un accidente con este diente? En caso afirmativo: ¿Qué y cuándo? ______________________________
Sí	**No**	¿Tiene su diente se siente suelto?
Sí	**No**	¿Su nariz se siente congestionada o siente que es posible que tenga un resfriado? En caso afirmativo: ¿Cuándo comienzan tus síntomas?______________________________
Sí	**No**	¿Aprietas la mandíbula, mueles o usas una guardia nocturna?
Sí	**No**	¿Tiene dolor en articulaciones de la mandíbula (ATM), estallidos o clics en la mandíbula, o problemas para abrir o cerrar la boca?
Sí	**No**	¿Usted va a su dentista regularmente? En caso afirmativo (marque): Mi último cuidado dental fue: ___ visita regular, ___occasional comprobar hacia arriba o ____emergency visitar solamente
Sí	**No**	¿Tiene ansiedad cuando vas al dentista? En caso afirmativo (marque): ___ algo aprensivo, ___ ansiedad moderada, ___ ansiedad severa.
Sí	**No**	¿Suele llevar más tiempo sentirse adormecido?

Firma del Paciente / Tutor: ______________________________ **Fecha:** ____________________

*** (Sólo para uso de oficina.) ***

Notas: ____

____

Dr. Nancy N Huynh, DDS

REDWOOD SHORES ENDODONTICS
358 Marine Pkwy, Ste. #400
Redwood Shores, CA 94065
650-592-6066

Name:____
(Last) (First) (MI)

I. CONSENT TO ENDODONTIC TREATMENT

Endodontic (root canal) treatment is an attempt to retain a tooth, which may otherwise require extraction. Although endodontic treatment has a high degree of success, it cannot be guaranteed. For a variety of reasons, a small number of root canal treatments will fail. When this occurs, the endodontic treatment can frequently be repeated and/or the area of infection can be approached surgically. These procedures are often technically more difficult than the original endodontic procedure. Occasionally, unexpected problems do arise during retreatment that require a reevaluation of treatment alternatives. Please understand that on rare occasions a tooth will not respond as desired, despite our best efforts. Therefore, these teeth must be extracted. Risks of endodontic treatment, however slight, are of two kinds: those risks associated with dental procedures in general, and those specific to endodontic treatment.

RISKS OF DENTAL TREATMENT IN GENERAL: These are complications resulting from the use of dental instruments, anesthetics, analgesics, and antibiotics. These complications include, but are not limited to pain, sensitivity, swelling, bleeding, infection; numbness and tingling sensation of the lips, chin, cheek, tongue, gums, and teeth; reactions to injections, thrombophlebitis (inflammation of the veins); jaw joint problems, muscle cramps and spasms, changes in occlusion (biting), referred pain to the ear, neck or head; loosening of teeth or restorations of teeth, swallowing or aspiration of instruments or fillings; brushing, delayed healing, sinus complications, and injury to tissues which may require additional surgery.

RISKS SPECIFIC TO ENDODONTIC TREATMENT: These risks include loss of tooth structure in gaining access to canals, fracture of tooth structure, fracture of instruments separated within the root canals, perforations (extra openings) of the crown of root of the tooth; damage to existing filling, crowns, porcelain veneers, or bridges; possible extension of root canal filling materials outside the root of the tooth into the jaw, and adverse reactions to irrigating solutions. During endodontic treatment, complications may be discovered which make completion of treatment difficult or impossible. These may include blocked or obstructed canals resulting from natural calcifications, filling, prior endodontic treatment, separated instruments, curved roots, periodontal (gum) disease, and fractures of the teeth.

ALTERNATIVES to endodontic treatment include no treatment, waiting for development of more definite symptoms, and extraction of the tooth. Risks of these choices include pain, swelling, bleeding, infection, loss of the tooth or adjacent teeth, and spread of infection to other parts of the body.

MEDICATIONS may be prescribed by the endodontist. Possible side effects include nausea, vomiting, allergic reactions (itching, hives) and gastrointestinal problems. Should any such reactions occur, please contact our office immediately. Medications for discomfort and sedation may cause drowsiness, lack of coordination and awareness which can be increased by the simultaneous use of alcohol or other drugs. It is advisable not to operate any vehicle or hazardous devise until fully recovered from these effects.

I understand the risks involved with treatment and with no treatment. It has been decided, by mutual consultation between myself and the doctor, the treatment is desirable for tooth # ______. I consent to the procedures in this area deemed advisable and necessary in the opinion of the doctor.

Patient/ Guardian Signature:_______________________________________ **Date:**_____________________________

II. NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At this office, we always keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment, for example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you either by phone or with a reminder card in the mail to remind you of an upcoming appointment. If you are not home, we may leave a message on voice mail or with a person who may answer the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your healthcare information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or phone number you prefer. In the event that you need a copy of your records and x-rays we will release them to you for a fee of $25.00. We also require a records release consent form be signed. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information. You have a right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of this change in writing.

*You may file a complaint to the Department of Health and Human Services, 200 Independence Ave. SW. Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Private Officer, Tiffany Cairo at 650 592-6066. This notice goes into effect as of April 14th, 2003.

Patient/ Guardian Signature:_______________________________________ **Date:**_____________________________

REDWOOD SHORES ENDODONTICS
358 Marine Pkwy, Ste. #400
Redwood Shores, CA 94065
650-592-6066

OFFICE FINANCIAL POLICY

Thank you for choosing our office to provide you with your root canal treatment. We are committed to providing you with excellent care, and timely payment of fees allows us to devote more time and effort to caring for you. Our Financial Policy is based on an open and honest discussion of our fees.

Payment in full is due at the time of service. We offer the following options of payment for treatment provided:

1. We accept Cash, Visa, MasterCard & CareCredit. **NO CHECKS ARE ACCEPTED.**
2. If you have dental insurance, your co-payment is due at the time of services. No exceptions!

Insurance

Our practice philosophy is to provide you with the best possible care. As a service to our patients, we will bill your insurance company. Your insurance policy is a contract between you and your insurance company. As a health care provider, we are not a part of this agreement. **Insurance polices vary, and services rendered may not be covered. If your insurance does not cover all or part of the treatment provided, you will be responsible for the payment that was not reimbursed by insurance. ALL BENEFITS QUOTED IN OUR OFFICE ARE ESTIMATES. Therefore, you are encouraged to contact your insurance company if you have any questions pertaining to your specific plan.** In the event my account exceeds 90 days after all insurance claims have been paid, I authorize my credit card on file to be charged for any remaining balance. In the event my credit card on file is declined and or expired I understand my account will be sent to a collection agency and or small claims court.

Our office is committed to helping our patients maximize their benefits, and will work with you to achieve maximum benefit for your coverage. We are always available to answer your questions.

Missed Appointment

The policy of this office is to charge for missed appointments, **50% of the scheduled treatment.** An appointment is considered “missed” if you do not show up for your appointment, or if you cancel your appointment with less than **48 hours notice**. Once an appointment has been made, this time has been reserved specifically for you. Keeping your scheduled appointments enables us to better serve your needs.

Financial Consent

The patient (or legal guardian) agrees to be fully responsible for payment of treatment provided by this office.

I understand and accept the above financial policy.

Patient/ Guardian Signature:______________________________________ **Date:** ______________________

Patient Name Printed:____ **Date:** ______________________

COVID-19 Statement

To our Redwood Shores Endodontics Community:

We hope this letter finds you and your family in good health. Our community has been through a lot over the last few months, and all of us are looking forward to resuming our normal habits and routines. While many things have changed, one thing has remained the same: our commitment to your safety.

Infection control has always been a top priority for our practice. Our infection control processes are made so that when you receive care, it's both safe and comfortable. We want to tell you about the infection control procedures we follow in our practice to keep patients and staff safe.

Our office follows infection control recommendations made by the American Dental Association (ADA), the U.S. Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA). We follow the activities of these agencies so that we are up-to-date on any new rulings or guidance that may be issued.

As dental healthcare providers during a pandemic and following the recommendation of the ADA, we will continue to see patients on an emergency and case-by-case basis if they are not showing symptoms such as: fever, persistent coughing, sore throat, headache, fatigue, loss of taste/smell, gastrointestinal upset, or shortness of breath.

You may see some changes when it is time for your next appointment. We made these changes to help protect our patients and staff. Please be understanding with our new check-in policies as they are in place for your safety and the safety of our community:

- Our office will communicate with you beforehand to ask some screening questions. You'll be asked those same questions again when you are in the office.
- We have hand sanitizer and face masks that we will ask you to use when you enter the office. You will also find some in the reception area and around the office for you to use as needed.
- You may see that our waiting room will no longer offer magazines and so forth, since those items are difficult to clean and disinfect.
- Appointments will be managed to allow for social distancing between patients. That might mean that you're offered fewer options for scheduling your appointment.
- Adults, please only bring yourself to your appointment. If you are a parent bringing your child, please only bring the child with the scheduled appointment.
- Your temperature will be taken at check-in. Anyone with a temperature of 100.4 or higher, will be rescheduled.

Please note, if you or someone you are in close contact with have recently traveled to one of the countries with large outbreaks of COVID-19 (China, Italy, Iran, or South Korea) or if you have been exposed to someone else who was diagnosed with COVID-19 or who was quarantined as a precaution, please wait 14 days until you see your dentist to make sure you have not caught the coronavirus. Persons displaying symptoms or has positive responses to screening questions may require a postponement to treatment.

We look forward to seeing you and are happy to answer any questions you may have about the steps we take to keep you, and every patient, safe in our practice. Thank you for being our patient. We value your trust and loyalty and look forward to welcoming back our patients, neighbors and friends.

Patient Screening Form

ADA®

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

IMPORTANT INTRUCTIONS TO PATIENT

1. **If you need to cancel your appointment please call 48 hours in advance.**
2. **If you have dental insurance, please furnish us the following information:**
   -Name of Insurance
   -Name of the person holding the insurance
   -Subscriber ID# or social security number
   -Date of birth
4. **Please bring a list of medications with you (if you are taking any).**
5. **Call the office if you develop a cold, fever, or sore throat prior to your appointment.**
6. **A Co-payment may be required on the day of service.**

DIRECTION TO OUR OFFICE:
Coming from the North (ie. San Francisco)

1. ***Take 101 S.***
2. ***Take Ralston Ave. (Exit 412) towards Marine Parkway***
3. ***Turn LEFT onto Ralston Ave.***
4. ***Ralston Ave. becomes Marine Parkway/Marine World Parkway***
5. ***Turn RIGHT onto Marina Drive***
6. ***Make an immediate left turn.***
7. ***Turn right into the first parking lot.***
8. ***358 Marine Parkway, Suite 400 (brown building)***

Coming from South (ie. San Jose)

1. ***Take 101 N.***
2. ***Take Ralston Ave. (Exit 412) towards Marine Parkway***
3. ***Turn RIGHT onto Ralston Ave.***
4. ***Ralston Ave. becomes Marine Parkway/Marine World Parkway***
5. ***Turn RIGHT onto Marina Dr.***
6. ***Make an immediate left turn.***
7. ***Turn right into the first parking lot.***
8. ***358 Marine Parkway, Suite 400 (brown building)***

Cuestionario sobre síntomas del Covid-19

Nombre: ____

(Apellido) (Nombre)

	Antes de la cita Fecha:	En la oficina Fecha:
¿Tiene fiebre o ha tenido calor o síntomas de fiebre recientemente en estos (14 a 21 días)?	Si ☐ No☐	Si ☐ No☐
¿Tiene dificultad para respirar?	Si ☐ No☐	Si ☐ No☐
¿Tienes tos?	Si ☐ No☐	Si ☐ No☐
¿Algún otro síntoma similar a la gripe, como malestia gastrointestinal, dolor de cabeza o fatiga?	Si ☐ No☐	Si ☐ No☐
¿Ha tenido pérdida recientemente de sabor o olfato?	Si ☐ No☐	Si ☐ No☐
¿Han estado en contacto con pacientes confirmados con covid-19 positivo? Los pacientes que están bien pero que tienen un familiar enfermo en casa con COVID-19 deben considerar posponer el tratamiento.	Si ☐ No☐	Si ☐ No☐
¿Tienen más de 60 años?	Si ☐ No☐	Si ☐ No☐
¿Tiene una enfermedad cardíaca, pulmonar, renal, diabetes o un trastorno autoinmune?	Si ☐ No☐	Si ☐ No☐
¿Ha viajado en los últimos 14 días a alguna región afectada por covid-19? (sea relevante para su ubicación)	Si ☐ No☐	Si ☐ No☐