Sikka Dental Corporation General Paperwork

Patient Information

Full Name:_____
First Name Middle Name Last Name

Sex: Male / Female Date of Birth: MO / DAY / YEAR AGE:_____ Social Security Number: FULL NUMBER REQUIRED
Marital Status: Single / Married / Separated / Divorced / Widowed Is patient a Minor? Yes / NO
Minors Primary Residence? Both Parents / Mother / Father / Stepparent / Guardian / OTHER:_____

Patients Occupation:_____ or Minors School:_____

Email Address:_____@_____.com

1. Main Phone Number: ( ) Type: Work / Cell / Home / Other:_____
2. Alternate Phone Number: ( ) Type: Work / Cell / Home / Other:_____

I understand that providing this information, is a consent for communication with Sikka Dental Corporation about any and all matters of my care and accounts. If I choose to decline email or text communication at a later time, Sikka Dental Corporation will accept an Optout request anytime received in writing.

Home Address:_____
House Number Street Name Unit # City Zip Code

Emergency Contact:_____
Name Phone Number Relationship

Financial Information

☐ **YES, this information is different from above.** ☐ **NO, there is no additional information, above details are the same.**

Guarantor Name (Responsible Payee):_____
Date of Birth: MO / DAY / YEAR Relation to patient: Parent / Guardian / Sibling / Other:_____

Billing Address:_____
House Number Street Name Unit # City Zip Code
Main Phone Number: ( ) Type: Work / Cell / Home / Other:_____

Email Address:_____@_____.com
By providing any contact information you authorize Sikka Dental Corp. or any third-party agents to any and all communication regarding treatment and your account.

How did you Hear about our office? ☐ **Internet** ☐ **Yelp** ☐ **Co-worker** ☐ **Family/Friend** ☐ **Outside Event/Flyer**

☐ **Medical Doctor** ☐ **Another Dentist** ☐ **Organization** ☐ **OTHER:_____**

Who may we thank for referring you to our office?:_____

Insurance Information

Dental Primary Insurance Company:_____ Phone#:_____
Claims Mailing Address:_____
Employer and/or Group Name:_____
Employees Name (Policy Holder):_____ Date of Birth: MO/DAY/YEAR
Relationship to Patient: Self / Parent / Spouse / Partner / Stepparent / Other:_____
Subscriber ID# -or- Social Security Number:_____Group/Policy Number:_____
☐ **YES** ☐ No **Secondary Dental Policy? - If, YES then please provide Sikka Dental the same details on the other policy.**

Medical Insurance Company:_____Phone#:_____
Subscriber ID# / Medical Record# / Medicaid / Medi-Care:_____
Group/Policy Number:_____

☐ **YES, I have read and understand the following Disclaimer Statement:** As a courtesy to our patients, Sikka Dental Corporation will help file insurance claim forms to your insurance carrier in an effort to collect account balances. Sikka Dental Corporation cannot guarantee or warrant any insurance payments, claim payments are paid based upon your groups plan provisions and limitations that are selected by your employer. Plan changes are subject to change without notice to Sikka Dental and unforeseen circumstances are a possibility. Any lack of payment from your insurance carrier will result in monies due to Sikka Dental Corporation and will need to be paid under the office policies and procedures in a timely manner._____ (initials)

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DENTAL HISTORY

Date of Last Dental Visit? MONTH/YEAR Date of Last Dental X-ray? MONTH/YEAR

Former Dentist Name or Facility Name:_____ City:_____

Why did you leave your last office?: Lack of Customer Service / Accounting Problem / Appointment Problems /
Other:_____

What is important to you in a dental office?: _____

_____

How often do you visit the dentist? ☐ Yearly checkups ☐ Twice a Year ☐ Only when I have a problem

Please choose the appropriate answers:

Yes / No Are you nervous about receiving dental treatment?
Yes / No Do you gag easily?
Yes / No Have you had previous problems with dental care?
If YES, explain:

Yes / No Are your teeth sensitive hot/cold/pressure/sweets?
Yes / No Do you have problems with teeth/fillings breaking?
Yes / No Are you aware of an uncomfortable bite?
Yes / No Do your gums feel tender and/or bleed?
Yes / No Does food catch between your teeth?
Yes / No Have you had periodontal (gum) treatment(s)?
Yes / No Do you get sores in or around your mouth?
Yes / No Do you have regular headaches/earaches/neck pains?
Yes / No Do you grind or clench you teeth?
Yes / No Do you hear "clicking" sound when you open/close your mouth?
Yes / No Does you jaw ever get "stuck"?

Yes / No Are you missing teeth that have not been replaced?
Yes / No Have you had excessive bleeding after an extraction?
Yes / No Have you had mouth sores that take long to heal?
Yes / No Do you have dental implants?
Yes / No Do you wear dentures (partials or full)?
Yes / No Do you have any crowns (caps) or bridges?
Yes / No Are you unhappy with the appearance of your teeth?
Yes / No Would you like your smile to look better?
Yes / No Would you like whiter teeth?
Yes / No Do you regularly use dental floss?
Yes / No Do you brush at least once daily?
Yes / No Do you use a manual toothbrush?
Yes / No Do you use an electric power brush?
Yes / No Is there anything else that you would like us to know?

MEDICAL HISTORY

Are you currently a patient of record with your Medical Doctor? ☐ YES ☐ NO When was your last visit? MONTH/YEAR

Your Medical Physicians Full Name:_____ Office Phone #: ( )

Group or Practice Name:_____ City:_____

Have you been Hospitalized in the last 2 years? ☐ YES ☐ NO

If YES, what for?_____

If YES, are you taking any medications, drugs, or pills (Please list below IN SECTION 6)? ☐ YES ☐ NO

WOMAN ONLY:

Are you Pregnant? ☐ YES, How far along?_____ ☐ NO Are you Nursing? ☐ YES ☐ NO

Are you taking Birth Control Pills? ☐ YES ☐ NO Are you on Hormone Therapy? ☐ YES ☐ NO

CIRCLE YES OR NO FOR ANY OF THE FOLOWING IF YOU PRESENTLY HAVE OR HAVE HAD IN THE CONDITION IN THE PAST:

1. ALLERGIES

Yes / No Aspirin
Yes / No Penicillin or other antibiotics
Yes / No Nitrous oxide
Yes / No Valium or other sedatives
Yes / No Latex
Yes / No Local anesthetic
Yes / No Codeine or other narcotics
Yes / No Food
Yes / No Metal

OTHER:_____

2. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

Yes / No Chest Pain
Yes / No Fainting spells
Yes / No Recent significant weight loss
Yes / No Fever
Yes / No Night Sweats
Yes / No Persistent cough
Yes / No Coughing up blood
Yes / No Bleeding problems
Yes / No Blood in urine
Yes / No Blood in stools
Yes / No Diarrhea or constipation
Yes / No Frequent urination
Yes / No Difficulty urinating
Yes / No Ringing in ears
Yes / No Headaches
Yes / No Dizziness
Yes / No Blurred vision
Yes / No Bruise easily
Yes / No Frequent vomiting
Yes / No Jaundice
Yes / No Dry Mouth
Yes / No Excessive thirst
Yes / No Difficulty swallowing
Yes / No Swollen ankles
Yes / No Joint pain or stiffness
Yes / No Shortness of breath
Yes / No Sinus problems

OTHER:_____

Sikka Dental Corporation General Paperwork

3. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING?

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Family history of heart disease	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart attack	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Artificial joint	Yes / No Diabetes	Yes / No Asthma
Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes	Yes / No Hepatitis
Yes / No Heart defects	Yes / No Tumors or cancer	Yes / No Sexual transmitted disease
Yes / No Heart murmurs	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Rheumatic fever	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Skin disease	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Hardening or arteries	Yes / No Emphysema/ other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Cosmetic surgery	Yes / No Eating disorders	Yes / No Tuberculosis

OTHER:_____

4. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING?

Yes / No Recreational drugs	Yes / No Tobacco in any form	Yes / No Antibiotics
Yes / No Over-the-counter medicines	Yes / No Alcohol	Yes / No Supplements
Yes / No Weight loss medications	Yes / No Bisphosphonate (Fosamax)	Yes / No Aspirin
Yes / No Anti-Depressants	Yes / No Herbal Supplements	

Please list all prescription medications BELOW in SECTION 6.

5. ALL PATIENTS

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain:_____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why:_____

Yes / No Have you ever taken Fen-Phen? If YES, when:_____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in PRIVATE?**

6. MEDICATION LIST

DRUG NAME	CONDITION THE DRUG IS TREATING	DOSAGE/FREQUENCY

7. If there is any additional conditions or information that you have not already listed above please use this space provided:

I certify that I have read and understand all 3 pages of the General Paperwork forms. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of the team, responsible for any errors or omissions that I may have made in the complete of this form.

_____ _____ _____ _____

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

Sikka Dental Corporation General Paperwork

OFFICE POLICES OR PROCEDURES

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain some of our office policies and procedures with our practice.

-PAYMENT: Payment is due at the time of services are rendered. Financial arrangements are discussed during the initial visit and a financial arrangement is completed in advance of performing any treatment with our practice. Once treatment is completed additional financial agreements may not be approved or offered. We accept most major credit cards, along with care credit master card. Please note that we do offer third party financing options and those payment arrangements are through you and the creditor you have applied to. Auto payment(s) are allowed based upon approval from a manager, if a payment is missed the total accrued balance will be debited from the card on file on the next payment date.

☐ I have read the above and agree to the financial terms. _____ (initial)

-Dental Benefits: Your dental benefits is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on their terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. Our practice may or may not be contracted with your dental benefit plan which will change some of your benefit details. We are required by your insurance company to collect the full patient's portion amount not covered by the dental benefit plan in full at the time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

☐ I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. I also understand that any and all patient portions payable to me determined by my policy are my responsibility. **YES / NO (Circle one)** _____ (initial)

-Scheduling Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 2 business days' notice to reschedule an appointment. With less then the 2 business days' notice an automatic minimum change of $50.00 will be charged to your account.

☐ I have read the above and agree to the scheduling terms. _____ (initial)

-Dental Treatment: We base our treatment plans on visual or x-rays completed during an exam appointment. It has been explained to me that during the course of a dental procedure(s), unforeseen conditions may be revealed that may necessitate and extension or the original procedure(s) or different procedure(s) then those listed above. I, therefore authorize and request that the treating providers perform such procedures as are medically necessary and desirable, in the exercise of their professional judgement. The authority granted under this agreement shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced. I understand that no guarantee or assurances has been made to be regarding the treatment which I have authorized and requested. I understand that each doctor is an individual practitioner and is individually responsible for the rendered treatment.

☐ I have read the above and agree to the treatment conditions. _____ (initial)

-Patient Communication:

Voice Messages: I understand that brief messages from the dental practice may be left on my home voicemail or with anyone who answers the phone at my home unless I have provided the practice with alternate instructions for communication. Any and all contact phone methods provided are approved and authorized to call for patient communication.

Email/Text: Except for appointment reminders and automated messages, we use secure methods to electronically communicate with our patients. There is some risk that any individually identifiable health information and other sensitive confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

☐ I hereby acknowledge and have read the above Patient Communication conditions and agree to all terms. I also understand that and any all communication methods provided to Sikka Dental can be cancelled or modified anytime per my request in writing. _____ (initial)

-Notice of Privacy Practices: I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me at any time by paper copy or electronically per my request. I have been given the opportunity to ask any questions I may have regarding this notice. _____ (initial)

-Dental Materials Fact Sheet: I hereby acknowledge that a copy of this practice's State of California Dental Materials Fact Sheet has been made available to me at any time by paper copy or electronically per my request. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ (initial)

☐ **YES,** I have read all above statements and have the opportunity to ask any questions I have regarding Sikka Dental's Office Policies and Procedures.

Patient/Guardian Signature:_____ Date:_____

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES 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 of Privacy Practices while it is in effect. This Notice of Privacy Practices takes effect August 2018 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law, and to make new Notice of Privacy Practices 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 of Privacy Practices and post the new Notice of Privacy Practices clearly and prominently at our practice location, on our website, and we will provide copies of the new Notice of Privacy Practices upon request.

You may request a copy of our Notice of Privacy Practices at any time. For more information about our privacy practices, or for additional copies of this Notice of Privacy Practices, please contact us using the information listed at the end of this Notice of Privacy Practices.

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 authorize federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the Protected Health Information of an inmate or patient.

Secretary of Health and Human Services. 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.

Workers' Compensation. We may disclose your Protected Health Information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Law Enforcement. We may disclose your Protected Health Information 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 Protected Health Information 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 Protected Health Information 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 Protected Health Information 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 of your information.
Coroners, Medical Examiners, and Funeral Directors. We may release your Protected Health Information 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 Protected Health Information 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 Protected Health Information:

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of Protected Health Information for marketing, and for the sale of Protected Health Information. We will also obtain your written authorization before using or disclosing your Protected Health Information for purposes other than those provided for in this Notice of Privacy Practices (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 or disclosing your Protected Health Information, 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 of Privacy Practices. You may also request access by sending us a letter to the address at the end of this Notice of Privacy Practices. 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-based 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 of Privacy Practices 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 Officer. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.
Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your Protected Health Information by submitting a written request to the Privacy Officer. 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 your 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 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 requests. 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 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 of Privacy Practices upon request, even if you have agreed to receive this Notice of Privacy Practices electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact our office at: **408-259-1280**
If you are concerned we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice of Privacy Practices. You also may submit a written complaint to the U.S. Department of Health and Human Services.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. The Health and Human Services contact information can be located at www.hhs.gov.
Our practice: **Sikka Dental Corp.**
Telephone: **408-259-1280**
Address: **150 North Jackson Avenue, Suite 203, San Jose, CA 95116**