# Neal Pham, D.D.S.

9888 Carroll Centre Rd. Ste 102. San Diego. Ca 92126
(858)547-9393

## ***Patient Information***

Patient's Name ____________ Date of Birth ____________ M ___ F ___ Home Phone # ____________

Patient or Parent's Work Phone # ____________ Cell Phone # ____________ E-mail Address ____________

Patient's Address ____________ City ____________ State _____ Zip ____________

Patient's Social Security # ____________ Driver's License # ____________ State ______ Zip ____________

Patient's Employer ____________ How Long? ____________ Occupation ____________

Work Address ____________ City ____________ State _____ Zip ____________

Spouse's Name ____________ Employer ____________ Work Phone # ____________

Person to Contact in Case of Emergency ____________ Phone # ____________

Whom May We Thank for Referring You? ____________

## ***Responsible Party***

Name of Person Responsible for This Account (or Insurance Subscriber) ____________ Relation to Patient ____________

Insurance Subscriber's Social Security # ____________ Date of Birth ____________

Insurance Co. ____________ Group # ____________ Dedutible ________ Max. Annual Benefit ____________

## ***Medical History***

Physician's Name ____________ Date of Last Visit ____________

Have you had any serious illnesses or operations? Yes ___ No ___ If yes, describe ____________

Have you ever had a blood transfusion? Yes ___ No ___ If yes, give approximate dates ____________

(Women) Are you pregnant? Yes ___ No ___ Nursing? Yes ___ No ____ Taking birth control pills? Yes ___ No ___

Check (x) if you have had any of the following:

__Arthritis, Rheumatism
__ Artificial Joints
__ Asthma
__ Cancer
__ Diabetes
__ Heart Problems
__ Hemophilia
__ Hepatitis
__ High Blood Pressure
__ HIV Positive
__ Kidney Disease
__ Psychiatric Care
__ Rheumatic Fever
__ Venereal Disease

Medications (Currently taking): ____________

Allergies to Medications: ____________

## ***Authorization and Release***

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

____________________________________ ____________________

Signature of Patient or Parent if Minor Date

**INFORMED CONSENT** PATIENT NAME______________________________CHART NO.__________

**1. WORK TO BE DONE**
I understand that I am having the following work done:

- ☐ Fillings
- ☐ Bridges
- ☐ Crowns
- ☐ Extractions
- ☐ Impacted Teeth Removed
- ☐ Root Canals
- ☐ Dentures
- ☐ Partials
- ☐ Periodontics
- ☐ Other ______________

**I acknowledge that I have received a copy of the Dental Materials Fact Sheet dated October 17, 2001.**

______________________________
**(patient signature) (date)**

**2. DRUG AND MEDICATIONS**
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting, and/or anaphylactic shock (*severe allergic reaction*).

**3. CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary.______________(patient's initials)

**4. REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth ______ ______________________________ and any others necessary under paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

**5. ANESTHESIA**
I realize the risks involved in receiving a local anesthetic, some of which are: partial facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage and/or numbness.

**6. CROWNS, BRIDGES AND CAPS**
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered, and that if I don't have the permanent crown(s) placed, permanent serious damage or loss of the tooth/teeth involved may ensue, and that if I delay placement I may cause the teeth involved to move so that the permanent crown no longer will fit properly.

**7. DENTURES - COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone change.

**8. ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment, and that this treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if I do not complete the prescribed treatment.

**9. PERIODONTAL LOSS (TISSUE AND BONE)**
I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions.______________(patient's initials)

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, as explained above.

The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me. I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary and desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Parasthesia), fractured jaw, etc., have been clearly explained to me.

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.**

✓ **Signature:**______________________________ **Date:**______________
Patient or Legal Representative

✓ **Witness:**______________________________ **Date:**______________

# Dr. Pham Dental Care

9888 Carroll Centre Rd. Ste 102, San Diego, Ca 92126
Neal Pham D.D.S.

## Office Guidelines and Procedures

Thank you for choosing our office as your health care provider. We are committed to your treatment being successful. We appreciate your understanding in our efforts to maintain respectful guidelines for our practice to keep the care and service extraordinary.

**Appointments**

We pre-plan and prepare diligently for your visit. We reserve a room and time exclusively for you so we can provide the highest level of attention and care to your needs. We strongly encourage all patients to keep their appointments. When time is lost due to last-minute changes, other patients in need of treatment cannot be seen and your treatment is delayed, often resulting in negative consequences.

- Should any scheduling changes be required, **we require at least 24 hours advance notice to avoid a $100.00 cancellation fee.**
- A deposit is required to reserve the treatment time which takes more than one hour (or a comprehensive consultation). **Deposit will be non-refundable if fail to cancel the appointment with less than a 48 hour notice.**

**Courtesy Reminders**

We consider all appointments confirmed when they are made and it implies your obligation to be present at your pre-arranged date and time. As a courtesy, we make every effort to remind patients by email, text, or telephone (only per patient's request) prior to their appointments but please do not depend on this courtesy.

***By initialing this section and signing below, you indicate that you understanding and agree to these appointment guidelines.***

***Initial*** __________

**Insurance**

We are pleased that you have dental insurance to help you with assistance in affording your dental care. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- Insurance is an agreement between you and your insurance company. The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party of that contract. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do our best to see that you receive the full benefits of your policy.

**Billing**

Payment is due at the time of service unless prior arrangements have been made. We accept cash, check (only if fund can be verified), and most credit cards for your convenience. Liens will not be accepted.

**Cell Phone**

I consent to the dental practice using my cell phone number ____________________________ to call or text (circle one or both) regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

***By initialing this section and signing below, you indicate that you understanding and agree to these appointment guidelines.***

***Initial*** __________

**Records**: Records will be kept for seven years as per legal requirements. Copies of x-rays and records can be transferred to other providers upon receipt of written notification from the patient. There will be a fee for processing x-rays/records transfer. It is expected that a patient would provide the office with **at least 72 hours notice** when requesting x-rays or records.

**Medications**: Medications refills will be considered during office hours only. This is to conform to California Pharmacy Statutes and prevent people from acting or posing as patients. This also prevents the possibility of people obtaining medicines by illegal means. Patient should contact their pharmacy 1-2 days prior to the needed refill as the prescribing physician may not be immediately available the same day the medication runs out. **Note: Due to state pharmacy regulations, refills will not be provided to any patient who has not been seen in this office for 6 months or more.**

***By initialing this section and signing below, you indicate that you understanding and agree to these appointment guidelines.***

***Initial*** __________

Thank you for your support in our efforts to provide you with a positive experience.

______________________________ ______________

Signature of patient or responsible party | Date

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ________________________________________, have received a copy of this office's Notice of Privacy Practices.

________________________________________
Please Print Name

________________________________________
Signature

________________________________________
Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

________________________________________

________________________________________

________________________________________

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04 / 14 / 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.99___ for each page, $ 20 __ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or 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. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

Contact Office: Neal Pham, D.D.S.

Telephone: (858)547-9393

Address: 9888 Carroll Centre Rd. Ste 102, San Diego, Ca 92126