LorenzanaPeriodontics

PERIODONTICS • ORAL PLASTIC SURGERY • DENTAL IMPLANT AESTHETICS

Welcome to Our Practice!

Thank you for choosing us as your experts in Periodontal and Dental Implant care. We want to do everything possible to serve you beyond your expectations.

In an effort to learn more about your preferences in the delivery of your dental care, we ask that you consider sharing your expectations below.

Comfort options:
From our warm office colors to our cozy blankets and pillows, our office is designed with your comfort in mind by striving to create a family home-like environment. We know that dental treatment can be stressful to many of our patients. This is why we also offer several options to reduce any anxiety you may have regarding your care. Let us know if you are interested in:

A. Nitrous oxide (laughing gas)
B. Oral sedation (similar to Valium)
C. Intravenous conscious sedation (twilight sleep)

Treatment discussions:
We know considering all the options and possibilities of care can sometimes be overwhelming, especially when working with multiple doctors during a course of treatment. In an effort to provide you with all the needed information required for you to make your best long term decision, we provide you with detailed treatment information regarding your options.

Please help us understand how you prefer we provide you with your clinical information:

A. Lots of details please
B. Use pictures or visual information
C. Just get to the point and let me ask questions

Financial Discussions:
Prior to providing services we will always review fees and address your expectations regarding potential insurance reimbursement. It is important to remember, dental insurance is different than medical insurance. Benefit coverage is often far more limited, and dental insurance companies will never guarantee their level of reimbursement before a service is performed. We will do our best to verify your potential benefits prior to service, but we are never able to provide you with the true amount your insurance will cover prior to service.

Appointment Reservations:
Unlike some medical or dental practices that overbook their appointment schedule, we are fully committed to providing you with individualized, compassionate, high quality care at each visit. We prepare prior to your visit to be sure you have an excellent, long lasting treatment outcome.

You will enjoy the comfort and clinical outcomes we are able to achieve by investing the time, focus, and dedication of our entire team to your care. Please consider your calendar carefully when scheduling with our practice. If you are not able to keep your appointment you will be missed.

We are privileged to be your choice in Periodontal and Dental Implant care. If you have any questions or concerns, please ask our friendly and knowledgeable office staff.

Signature: Responsible Party ________________________ Date ___________

(Please do not sign until you have read this form. Thank you!)

TIME 10:43 AM DATE 1/13/2020

PATIENT REGISTRATION

ID: ______ Chart ID: ______

First Name: ______ Last Name: ______ Middle Initial: ______

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ______

Responsible Party (if someone other than the patient)

First Name: ______ Last Name: ______ Middle Initial: ______

Address: ______ Address 2: ______

City, State, Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Birth Date: ______ Soc Sec: ______ Drivers Lic: ______

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: ______ Address 2: ______

City: ______ State / Zip: ______ Pager: ______

Home Phone: ______ Work Phone: ______ Ext: ______ Cellular: ______

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ______ Age: ______ Soc Sec: ______ Drivers Lic: ______

E-mail: ______ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: ______ Pref. Dentist: ______

Employer ID: ______ Pref. Pharmacy: ______

Carrier ID: ______ Pref. Hyg: ______

Section 3

Primary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City, State, Zip: ______ City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Secondary Insurance Information

Name of Insured: ______ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ______ Insured Birth Date: ______

Employer: ______ Ins. Company: ______

Address: ______ Address: ______

Address 2: ______ Address 2: ______

City, State, Zip: ______ City, State, Zip: ______

Rem. Benefits: ______ Rem. Deduct: ______

Lorenzana Periodontics

Medical History Form

INITIALS: ________

PATIENT NAME: ____________ BIRTH DATE: ____________ DATE CREATED: ____________

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 ALL of the following questions.**

Question	Answer
Are you currently under a physician's care?	O Yes O No
If YES:	
Have you ever been hospitalized or had a major operation?	O Yes O No
If YES:	
Have you ever had a serious head or neck injury?	O Yes O No
If YES:	
Are you taking any medications, pills, or drugs?	O Yes O No
If YES:	
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No
If YES:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes O No
If YES:	
Are you on a special diet?	O Yes O No
If YES:	
Do you use tobacco? How long? How much?	O Yes O No
If YES:	
Do you use controlled substances?	O Yes O No
If YES:	
Are you diabetic? Latest HbA1c?	O Yes O No
If YES:	
Family history of diabetes?	O Yes O No
If YES:	

WOMEN: Are you…		
☐ Pregnant/Trying to get pregnant?	☐ Nursing?	☐Taking oral contraceptives?

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Medical History Form

INITIALS: ________

Are you ALLERGIC (rash, hives, swollen throat, anaphylaxis) to any of the following?			
☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa drugs	☐ Local anesthetics
☐ Food allergy	☐ Other? O Yes O No If YES:		

Do you have or have you had any of the following? (Circle Y or N for each)					
AIDS/HIV Positive	Y / N	Excessive Bleeding	Y / N	Lung Disease	Y / N
Alzheimer's Disease	Y / N	Excessive Thirst	Y / N	Mitral Valve Prolapse	Y / N
Anaphylaxis	Y / N	Fainting Spells/Dizziness	Y / N	Osteoporosis	Y / N
Anemia	Y / N	Frequent Cough	Y / N	Pain in Jaw Joints	Y / N
Angina	Y / N	Frequent Diarrhea	Y / N	Parathyroid Disease	Y / N
Arthritis/Gout	Y / N	Frequent Headaches	Y / N	Psychiatric Care	Y / N
Artificial Heart Valve	Y / N	Genital Herpes	Y / N	Radiation Treatments	Y / N
Artificial Joint	Y / N	Glaucoma	Y / N	Recent Weight Loss	Y / N
Asthma	Y / N	Hay Fever	Y / N	Renal Dialysis	Y / N
Blood Disease	Y / N	Heart Attack/Failure	Y / N	Rheumatic Fever	Y / N
Blood Transfusion	Y / N	Heart Murmur	Y / N	Rheumatism	Y / N
Breathing Problems	Y / N	Heart Pacemaker	Y / N	Scarlet Fever	Y / N
Bruise Easily	Y / N	Heart Trouble/ Disease	Y / N	Shingles	Y / N
Cancer	Y / N	Hemophilia	Y / N	Sickle Cell Disease	Y / N
Chemotherapy	Y / N	Hepatitis A	Y / N	Sinus Trouble	Y / N
Chest Pains	Y / N	Hepatitis B or C	Y / N	Spina Bifida	Y / N
Cold sores/Fever Blisters	Y / N	Herpes	Y / N	Stomach/Intestinal Disease	Y / N
Congenital Heart Disorder	Y / N	High Blood Pressure	Y / N	Stroke	Y / N
Convulsions	Y / N	High Cholesterol	Y / N	Swelling of Limbs	Y / N
Yellow Jaundice	Y / N	Hives or Rash	Y / N	Thyroid Disease	Y / N
Cortisone Medicine	Y / N	Hypoglycemia	Y / N	Tonsilitis	Y / N
Diabetes	Y / N	Irregular Heartbeat	Y / N	Tuberculosis	Y / N
Drug Addiction	Y / N	Kidney Problems	Y / N	Tumors or Growths	Y / N
Easily Winded	Y / N	Leukemia	Y / N	Ulcers	Y / N
Emphysema	Y / N	Liver Disease	Y / N	Venereal Disease	Y / N
Epilepsy or Seizures	Y / N	Low Blood Pressure	Y / N		

Medical History Form

Have you ever had any serious illness not listed above? Y / N If YES: ____________________

____

____

Comments:

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 or Guardian: X ____________________ **Date:** ____________________

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Lorenzana Periodontics and Dental Implants

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. If you have any questions about this notice, please contact our Privacy Officer.

Understanding Your Health Record/Information
Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to
- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 Code of Federal Regulations (CFR) 164.522. Requests for restrictions on disclosure of PHI to your health plan for health care items or services paid for out-of -pocket must be accepted.
- obtain a paper copy of the Notice of Privacy Practices upon request
- inspect and obtain a paper or electronic copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528 and HB300 (paper or electronic)
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528

- request communications of your health information by alternative means or at alternative locations
- receive a notice of a breach of "unsecured" protected health information
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities
This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- notify you of a breach of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information (PHI) we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose or sell your health information without your written authorization, except as described in this notice.

To Report a Problem
If you have questions and would like additional information, you may contact this office nd speak to our Privacy Officer at (210) 492-3519.

If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations
Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Operations:
1. **Risk Management** - Members of the medical staff or the risk or quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
2. **Business Associates -** There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services,

transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

3. **Notification –** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
4. **Communication With Family -** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
5. **Research -** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
6. **Funeral Directors –** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
7. **Organ Procurement Organizations** – Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
8. **Marketing –** We may contact you to provide appointment reminders or face-to-face information about treatment alternatives or other health-related benefits and services that may be of interest to you.
9. **Food and Drug Administration (FDA) –** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recalls, repairs or replacement.
10. **Workers' Compensation –** We may disclose 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.
11. **Public Health –** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
12. **Law Enforcement –** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
13. **Schools -** We may disclose childhood immunization records to schools.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Effective Date: January 1, 2009

Privacy Officer: Samantha Garcia

Telephone: (210) 492-3519

Address: 3519 Paesano's Parkway, Suite 103
San Antonio, TX 78231

Acknowledgement Of Receipt
Of
Notice of Privacy Practices

I, ____have received a copy of

(Name of Patient)

Lorenzana Periodontics Group, P.A., Notice of Privacy Practices.

____

(Signature of Patient/Parent or Legal Guardian)

Staff Will Fill Out This Section if Signature Is Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of Our Notice of Privacy Practices, but it could not be obtained for the following reasons:

______ Patient refused to sign.

______ Emergency situation kept us from obtaining the patient's signature.

______ Language barriers kept us from obtaining the patient's signature.

______ Other: ____