PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE: _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE ___ ZIP CODE _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____ [ ]MALE [ ] FEMALE

CHECK APPROPRIATE BOX: [ ] MINOR [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] WIDOWED [ ] SEPARATED

IF COLLEGE STUDENT; F.T./P.T. , NAME OF SCHOOL: _____ CITY _____ STATE ___

PATIENT'S OR PARENT'S/ GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____

SPOUSE OR PARENT'S/ GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ PHONE # _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? [ ] YES [ ] NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

INSURANCE CARRIER _____ TEL# _____ GRP# _____ POLICY/ ID# _____

INS. CARRIER ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ MAX ANNUAL BEBENFITS? _____ HOW MUCH HAVE YOU USED? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE [ ] YES [ ] NO IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

INSURANCE CARRIER _____ TEL# _____ GRP# _____ POLICY/ ID# _____

INS. CARRIER ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

X _____ SIGNATURE OF PATIENT OR PARENT / GUARDIAN IF MINOR

REGISTRATION

NAME: DATE:

Medical History

	Yes	No
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐

For what? _____

What medications are you taking? _____

_____

FAMILY PHYSICIAN _____

Phone No. _____

Do you smoke?	☐	☐
Have you ever been prescribed bisphosphonates?	☐	☐
(Women) Are you pregnant? How many months?	☐	☐

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
Material Allergies (Latex, wool, metal, chemicals)	☐	☐	Radiation Treatment	☐	☐
Fen-Phen/Redux	☐	☐	Arthritis	☐	☐
High Blood Pressure	☐	☐	A.I.D.S./A.R.C./HIV Pos.	☐	☐
Heart Murmur	☐	☐	Hepatitis A(Infectious)	☐	☐
Rheumatic Fever	☐	☐	Hepatitis B (Serum)	☐	☐
Congenital Heart Lesions	☐	☐	Liver Disease	☐	☐
Mitral Heart Valve	☐	☐	Psychiatric Treatment	☐	☐
Heart Pacemaker	☐	☐	Glaucoma	☐	☐
Heart Surgery	☐	☐	Chemotherapy	☐	☐
Artificial Joints	☐	☐	(cancer, leukemia)	☐	☐
Stroke	☐	☐	Venereal Disease	☐	☐
Kidney Trouble	☐	☐	Bruise Easily	☐	☐
Allergies or Hives	☐	☐	Emphysema	☐	☐
Asthma or Hay Fever	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Epilepsy or Seizures	☐	☐
Thyroid Disease	☐	☐	Drug Addiction	☐	☐
Osteoporosis	☐	☐	Hemophilia	☐	☐
			Other	☐	☐

Dental History

HOW LONG SINCE you have seen a Dentist? _____

DATE of last COMPLETE dental exam _____

DATE of last FULL MOUTH X-RAYS _____

	YES	NO
Have you had any PERIODONTAL (GUM) Treatment?	☐	☐
Do your gums BLEED or feel TENDER or IRRITATED	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets or pressure (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES or NECK PAIN?	☐	☐
Have you worn BRACES on your teeth before? (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother your?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐
Does food CATCH between your teeth?	☐	☐
Do you have any CLICKING in your jaw?	☐	☐
You have any POPPING in your jaw?	☐	☐
Do you feel you have BAD BREATH?	☐	☐
Have you EVER had your teeth BLEACHED?	☐	☐
Would you like to have WHITER teeth?	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐

Nitrous Oxide ☐ Codeine ☐ Penicillin ☐

None of the above ☐

Are you aware of being allergic to other medications or substances? _____

If yes, Specify: _____

Is there any other Medical or Dental information that you feel we should know about? _____

_____

_____

DATE: _____ **SIGNATURE** _____

Annual Updates

Date: _____ Signature _____

Changes in Health ☐ NO ☐ YES (Specify) _____

Date: _____ Signature _____

Changes in Health ☐ NO ☐ YES (Specify) _____

Date: _____ Signature _____

Changes in Health ☐ NO ☐ YES (Specify) _____

Date: _____ Signature _____

Changes in Health ☐ NO ☐ YES (Specify) _____

Anthony Vitarelli, DDS
2075 Forest Ave. Suite 6
San Jose, CA 95128
408-287-3892

Payment Policy for Services Rendered

Dental Insurance Patients

- If you are unable to keep an appointment that has been reserved for you, we require that you provide us with at least 24 hour advanced notice. If we do not receive this advanced notice we will charge your account a $50 cancelation fee.
- There will be a returned check fee of $30
- Please be aware that even though you have Dental Insurance, your account is your responsibility, not that of your insurance company.
- Co-payments and deductibles are due at the time services are rendered.
- Before or during your initial visit, we will contact your insurance company to obtain benefit information. A disclaimer is given to us saying that they do not guarantee payment and the payment is based on the percentage of what they consider Maximum Plan Allowance.
- WE URGE YOU TO BE FULLY AWARE OF THE PROVSIONS OF YOUR POLICY, AS WE ARE NOT RESPONSIBLE FOR ANY ERRORS, OMISSIONS, OR MISINFORMATION GIVEN TO US BY YOUR INSURANCE COMPANY.
- As a courtesy, we will provide a written treatment estimate for any treatment upon request. The treatment we recommended will be based upon our professional judgement and what is in YOUR long-term best interest, not on whether you are covered by a dental benefit plan. The treatment estimate is not a guarantee of benefits or payment, it is an **ESTIMATE** only!
- We do our best to provide the most accurate information to you; however, it is possible that your account may have a balance after your insurance has paid. We ask that the balance be paid upon receipt of your billing statement.
- Once your insurance payment has been received, or sixty days after treatment whichever occurs first, your account will be balanced. We may owe you a refund or you may owe us a payment. If you have a refund, how would you like us to handle it?
    - Apply refund to my account for future treatments
    - Mail check to: _____
- For your convenience, our office accepts Visa, MasterCard, Discover, Cash, Checks, and Care Credit/Lending Club. (Care Credit and Lending Club are a financing option with approved credit.)
- Occasionally, an insurance company will send a payment to a patient. If this occurs, please bring the attached stub and the check.

By Signing below you agree to the terms of this policy:

_____	_____	_____
Patient Name (Parent/Guardian if minor)	Signature	Date

Anthony Vitarelli DDS

2075 Forest Avenue, Suite 6

San Jose, CA 95128

(408)287-3892

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE TO PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of this office's Notice of Privacy Practice.

_____ _____

Print Name Signature

_____

Date

For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us for obtaining acknowledgement
- Other (please specify)

Anthony Vitarelli DDS

NOTICE OF PRIVACY PRACTICE

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.
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 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 April 13, 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 practice, or for additional copies of this Notice, please contact us using the information at the ends 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 the services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our health care operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conduction training programs, accreditations, 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; 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 you 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 disclose of your health information, we will disclose health information based on a determination using our professional judgement 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.
Require 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 reasonable 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 the 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 a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointments reminders (such as voicemail messages, postcards, or letters).

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 formal other than photocopies. We will use the format that you requested 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 change your reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending is a letter to the address at the end if this Notice. If you request copies, we will charge $1 for each page, $20 per hour for the staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternant format, we will charge a cost-bases fee for providing your health information in that format. If you prefer, we will prepare a summary or a full explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a complete 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 information for purposes, other than treatment, payment, healthcare operations, and certain 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-bases fee for responding to this additional request.
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 this additional restriction, but if we do, we will abide by our agreement (except in emergency)
Alternative Communication: You have the right to request that we communicate with you about your health information any 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 of how payments will be handled under the alternative means or lavation 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 website or electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices 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 location, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with this address to file your complaint to 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 Department of Health and Human Services.
Contact Officer-Stephanie Wells Telephone: (408)287-3892 Fax: (408)293-7765
E-mail: Stephanie.drvitarelli@gmail.com
Address: 2075 Forest Ave, Suite 6, San Jose, CA 95128