Welcome

James A. Snow, D.D.S.

PACIFIC DENTAL CENTER

General and Cosmetic Dentistry

156 N. El Camino Real

Encinitas, California 92024

(760) 436-7222

PACIFIC DENTAL CENTER

Bright Ideas for Brighter Smiles

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Name: _____

Email Address: _____

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/_____ Age: _____ SS#:_____

Home Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____) _____ Cell #: (____) _____

Wk #: (____) _____ Ext: _____ DL #: _____

Employer: _____

Employer"s Address: _____

How long there? _____ Occupation: _____

Where & when are the best times to reach you? _____

Whom may we Thank for referring you? _____

Previous/Present Dentist: _____

Last Visit Date: _____

2 Responsible Party Information

His/Her Name: _____

Employer: _____

Wk #: (____) _____ Ext: _____ SS#:_____

Birthdate: ___/___/_____ DL #: _____

Person Responsible for Account: _____

Billing Address: _____

Employer: _____

Wk #: (____) _____ Ext: _____ Hm #:(____) _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #:(Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthday: __/___/_____ Insured's SS#: _____

Insured's Employer: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #:(Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____

Insured's Birthday: __/___/_____ Insured's SS#: _____

Insured's Employer: _____

4 Medical History

Do you have a personal physician?

Physician"s Name: _____

Phone #: (____) _____ Last Visit Date: _____

Wk #: (____) _____ Ext: _____ DL #: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (___)_____

PLEASE COMPLETE BOTH SIDES

5 Medical History continued

Your current physical health is:

☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician: ☐ Yes ☐ No

Please explain: _____

Are you taking any prescription/over-the-counter drugs?

☐ Yes ☐ No

Please list each one: _____

_____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Hepatitis
Y N Alcohol/Drug Abuse	Y N Herpes/Fever Blisters
Y N Anemia	Y N High Blood Pressure
Y N Arthritis	Y N Hospitalized For Any Reason
Y N Artificial Bones/Joints/Valves	Y N HIV/Aids
Y N Blood Transfusion	Y N Kidney Problems
Y N Cancer/Chemotherapy	Y N Liver Disease
Y N Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Disease	Y N Pacemaker
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Radiation Treatment
Y N Emphysema	Y N Rheumatic/Scarlet Fever
Y N Epilepsy	Y N Seizures
Y N Fainting Spells	Y N Shingles
Y N Frequent Headaches	Y N Sickle Cell Disease
Y N Glaucoma	Y N Sinus Problems
Y N Hay Fever	Y N Stroke
Y N Heart Attack	Y N Thyroid Problems
Y N Heart Murmur	Y N Tuberculosis (TB)
Y N Hearth Surgery	Y N Ulcers
Y N Hemophilia	Y N Veneral Disease

Please list any medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N Penicilin	Y N Erythromycin	Y N Aspirin
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics		Y N Other

Please list any other drugs that you are allergic to: _____

_____

_____

6 Dental History

Why have you come to the dentist today?

_____

_____

Do you need to be premedicated before dental treatment?

☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you or have you ever experience pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

Have you ever taken Phen-Phen? ☐ Yes ☐ No

Terms & Conditions

I understand that the information that I have given today is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform necessary dental services that I may need during diagnosis and treatment with my informed consent. As a condition of treatment by the office, I understand financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. I hereby authorize my insurance company to pay directly to my dentist benefits accruing under my policy. A service charge of 1-1/2% per month (18% per annum - but in no event more than the maximum possible rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date. I understand the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any other term or condition. I further agree that in the event either this officer or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant permission to you, or your assigns, to telephone me at my home or my work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

Signature: _____ Date: _____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor"s comments: _____

_____

MEDICAL HISTORY UPDATE:

1. Date: _____ **Comments:** _____ **Signature:** _____

2. Date: _____ **Comments:** _____ **Signature:** _____

3. Date: _____ **Comments:** _____ **Signature:**

Pacific Dental Center Office Policies

Financial Policy:

Treatment cost estimates are provided to you, the patient, and prior to treatment. We will file insurance claims on your behalf; however your shares of costs are due at the time of service. Although we file insurance claims for you, ultimately the responsibility rests with the patient or responsible party. If after 60 days, no payment is received from your insurance carrier, payment in full will be due from the patient at that time.
All accounts over 90 days will be subject to an 18% per annual finance charge. Any accounts sent to a collection service will be surcharged an additional fee.

Initials:_____

Local Anesthetics

The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in heart rate but will return to normal. Common complications that can occur from local anesthetic but are not limited to: are pain, swelling, and bruising. Rare serious complications may occur that can include but are not limited to: permanent numbness, abnormal sensation, transient blindness.

Initials:_____

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change or add procedures due to condition found while working on the teeth that were not discovered during an examination. I give permission to Dr. Snow to make any/all changes and additions as necessary once I have been informed of these changes and consented to them. I also understand that by not following my dentist's recommendation, delayed treatment can lead to but not limited to more discomfort, increased complexity of the treatment outcome, or eventual loss of teeth.

Initials:_____

Cancellation Policy:

All appointments require 2 business days' notice of cancellation. A minimum of $75 will be assessed if a cancellation occurs in less. Please note we do not accept cancellations via text, voicemail or email.

Initials:_____

Authorization for Signature on File:

I hereby authorize the office of Pacific Dental Center to affix my name to any and all claims and documents as related to any and all benefits due me and my dependents through my employment with my employer. I further authorize payment of dental benefits otherwise payable to me, directly to Pacific Dental Center. A photocopy of this document acts as the original.

Initials:_____

_____ Date:_____

Patient Signature

_____

Office Witness

HEALTH INFORMATION PRIVACY
POLICIES & PROCEDURES

These Health Information Privacy Policies & Procedures implement our obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a healthcare provider.

We implement these Health Information Privacy Policies and Procedures as a matter of sound business practice; to protect the interests of our patients; and to fulfill our legal obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), its implementing regulations at 45 CFR Parts 160 and 164 (65 Fed. Reg 82462 (Dec. 28, 2000)) ("Privacy Rules"), as amended (67 Fed. Reg. 53182 [Aug. 14, 2002]), and state law that provides greater protection or rights to patients than the Privacy Rules.

As a member of our workforce or as our Business Associate, you are obligated to follow these Health Information Privacy Policies & Procedures faithfully. Failure to do so can result in disciplinary action, including termination of your employment or affiliation with us.

These Policies & Procedures address the basics of HIPAA and the Privacy Rules that apply in our dental practice. They do not attempt to cover everything in the Privacy Rules. The Policies & Procedures sometimes refer to forms we use to help implement the policies and to the Privacy Rules themselves when added detail may be needed.

Please note that while the Privacy Rules speak in terms of "individual" rights and actions, these Policies & Procedures use the more familiar word "patient" instead; "patient" should be read broadly to include prospective patients, patients of record, former patients, their authorized representatives, and any other "individuals" contemplated in the Privacy Rules.

If you have questions or doubts about any use or disclosure of individually identifiable health information or about your other obligations under these Health Information Privacy Policies & Procedures, the Privacy Rules or other federal or state law, please contact our office. This policy was adopted effective 4/14/03

1. General Rule: No Use or Disclosure

Our dental office must not use or **disclose protected health information (PHI),** except as these Privacy Policies & Procedures permit or require.

2. Acknowledgement and Optional Consent

Our dental office will make a good faith effort to obtain a written acknowledgement of receipt of our **Notice of Privacy Practices** (see Section 9) from a patient before we use or disclose his or her protected health information (PHI) for treatment, to obtain payment for that treatment, or for our healthcare operations (TPO).

Our dental office's use or disclosure of PHI for our payment activities and healthcare operations may be subject to the minimum necessary requirements (see Section 7).

Our dental office will become familiar with our state's privacy laws. If required by our state law, or as directed by the dentist, we will also seek **Consent** from a patient before we use or disclose PHI for TPO purposes – in addition to obtaining an Acknowledgement of receipt of our **Notice of Privacy Practices**.

a) Obtaining Consent – If consent is to be obtained, upon the individual's first visit as a patient (or next visit if already a patient), our dental office will request and obtain the patient's written **Consent** for our use and disclosure of the patient's PHI for treatment, payment, and healthcare operations.

Any consent we obtain must be on our **Consent** form, which we may not alter in any way. Our dental office will include the signed **Consent** form in the patient's chart.

b) Exceptions – Our dental office does not have to obtain the patient's Consent in emergency treatment situations; when treatment is required by law; or when communications barriers prevent consent.

c) Consent Revocation – A patient from whom we obtain consent may revoke it at any time by written notice. Our dental office will include the revocation in the patient's chart. There is space at the bottom of our **Consent** form where the patient can revoke the consent.

d) Applicability – Consent for use or disclosure of PHI should not be confused with informed consent for dental treatment. This section applies to our practice.

3. Authorization

In some cases we must have proper, written **Authorization** from the patient (or the patient's personal representative) before we use or disclose a patient's PHI for any purpose (except for TPO purposes) or as permitted or required without consent or authorization (see Sections 3, 4, or 5).

Our dental office will use the **Authorization** form. We will always act in strict accordance with an **Authorization.**

a) Authorization Revocation – A patient may revoke an authorization at any time by written notice. Our dental office will not rely on an **Authorization** we know has been revoked.

b) Authorization from Another Provider – Our dental office will use or disclose PHI as permitted by a valid **Authorization** we receive from another healthcare provider.

Our dental office may rely on that covered entity to have requested only the minimum necessary protected PHI. Therefore, our dental office will not make our own "minimum necessary" determination, unless we know that the **Authorization** is incomplete, contains false information, has been revoked, or has expired.

c) Authorization Expiration – Our dental office will not rely on an **Authorization** we know has expired.

4. Oral Agreement

Our dental office may use or disclose a patient's PHI with the patient's **Oral Agreement** or if the patient is unavailable subject to all applicable requirements.

Our dental office may use professional judgment and our experience with common practice to make reasonable inferences of the patient's best interest in allowing a person to act on behalf of the patient to pick up dental/medical supplies, X-rays, or other similar forms of PHI.

5. Permitted Without Acknowledgement, Consent Authorization or Oral Agreement

Our dental office may use or disclose a patient's PHI in certain situations, without **Authorization** or **Oral Agreement**. In our dental office, these disclosures are not likely to be frequent.

a) Verification of Identity – Our dental office will always verify the identity of any patient, and the identity and authority of any patient's personal representative, government or law enforcement official, or other person, unknown to us, who requests PHI before we will disclose the PHI to that person.

Our dental office will obtain appropriate identification and, if the person is not the patient, evidence of authority. Examples of appropriate identification include photographic identification card, government identification card or badge, and appropriate document on government letterhead. Our dental office will document the incident and how we responded.

b) Uses or Disclosures Permitted under this Section 5 – The situations in which our dental office is permitted to use or disclose PHI in accordance with the procedures set out in this Section 5 are listed below.

- Our dental office may disclose a patient's PHI to that patient on request.
- Our dental office may disclose to a patient's personal representative PHI relevant to the representative capacity. We will not disclose to a personal representative we reasonably believe may be abusive to a patient any PHI we reasonably believe may promote or further such abuse.
- Our dental office will not use or disclose a patient's PHI for fundraising purposes without the patient's **Authorization**.
- Our dental office will not use or disclose PHI for marketing without a patient's **Authorization** unless the marketing is in the form of a promotional gift of nominal value that we provide, or face-to-face communications between us and the patient.
- Our dental office may use or disclose PHI in the following types of situations, provided procedures specified in the Privacy Rules are followed:

1. For public health activities;
2. To health oversight agencies;
3. To coroners, medical examiners, and funeral directors;
4. To employers regarding work-related illness or injury;
5. To the military;
6. To federal officials for lawful intelligence, counterintelligence, and national security activities;
7. To correctional institutions regarding inmates;
8. In response to subpoenas and other lawful judicial processes;
9. To law enforcement officials;
10. To report abuse, neglect, or domestic violence;
11. As required by law;
12. As part of research projects; and
13. As authorized by state worker's compensation laws.

6. Required Disclosures

Our dental office will disclose protected health information (PHI) to a patient (or to the patient's personal representative) to the extent that the patient has a right of access to the PHI (see Section 10); and to the U.S. Department of Health and Human Services (HHS) on request for complaint investigation or compliance review.

Our dental office will use the disclosure log to document each disclosure we make to HHS.

7. Minimum Necessary

Our dental office will make reasonable efforts to disclose, or request of another covered entity, only the **minimum necessary** protected health information (PHI) to accomplish the intended purpose.

There is **no minimum necessary** requirement for disclosures to or requests by one another in our dental office or by a healthcare provider for treatment; permitted or required disclosures to, or for disclosure requested and authorized by, a patient; disclosures to HHS for compliance reviews or complaint investigations; disclosures required by law; or uses or disclosures required for compliance with the HIPAA Administrative Simplification Rules.

a) Routine or Recurring Requests or Disclosures – Our dental office will follow the policies and procedures that we adopt to limit our routine or recurring requests for our disclosures of PHI to the minimum reasonably necessary for the purpose.

b) Non-Routine or Non-Recurring Requests or Disclosures – No non-routine or non-recurring request for or disclosure of PHI will be made until it has been reviewed on a patient-by-patient basis against our criteria to ensure that only the minimum necessary PHI for the purpose is requested or disclosed.

c) Other's Requests – Our dental office will rely, if reasonable for the situation, on a request to disclose PHI being for the minimum necessary, if the requester is: (a) a covered entity; (b) a professional (including an attorney or accountant) who provides professional services to our practice, either as a member of our workforce or as our **Business Associate**, and who represents that the requested information is the minimum necessary; (c) a public official who represents that the information requested is the minimum necessary; or (d) a researcher presenting appropriate documentation or making appropriate representations that the research satisfies the applicable requirements of the Privacy Rules.

d) Entire Record – Our dental office will not use, disclose, or request an entire record, except as permitted in these Policies & Procedures or standard protocols that we adopt reflecting situations when it is necessary.

e) Minimum Necessary Workforce Use – Our dental office will use only the minimum necessary PHI needed to perform our duties.

8. Business Associates

Our dental office will obtain satisfactory assurance in the form of a written contract that our **Business Associates** will appropriately safeguard and limit their use and disclosure of the protected health information (PHI) we disclose to them.

These **Business Associate** requirements are not applicable to our disclosures to a healthcare provider for treatment purposes. The **Business Associate Contract Terms** document contains the terms that federal law requires be included in each **Business Associate Contract**.

a.) Breach by Business Associate – If our dental office learns that a **Business Associate** has materially breached or violated its **Business Associate Contract** with us, we will take prompt, reasonable steps to see that the breach or violation is cured.

If the **Business Associate** does not promptly and effectively cure the breach or violation, we will terminate our contract with the **Business Associate**, or if contract termination is not feasible, report the **Business Associate's** breach or violation to the U.S. Department of Health and Human Services (HHS).

9. Notice of Privacy Practices

Our dental office will maintain a **Notice of Privacy Practices** as required by the Privacy Rules.

a) Our Notice – Our dental office will use and disclose PHI only in conformance with the contents of our **Notice of Privacy Practices**. We will promptly revise a **Notice of Privacy Practices** whenever there is a material change to our uses or disclosures of PHI to legal duties, to the patients' rights or to other privacy practices that render the statements in that Notice no longer accurate.

Form 1, Notice of Privacy Practices, found in this Privacy Kit, contains the terms that federal law requires.

b) Distribution of Our Notice – Our dental office will provide our **Notice of Privacy Practices** to any person who requests it, and to each patient no later than the date of our first service delivery after April 14, 2003.

Our dental office will have our **Notice of Privacy Practices** available for patients to take with them. We will also post our **Notice of Privacy Practices** in a clear and prominent location where it is reasonable to expect patients seeking services from us will be able to read the Notice.

c) Acknowledgement of Notice – Our dental office will make a good faith effort to obtain from the patient a written Acknowledgement of receipt of our **Notice of Privacy Practices**.

Our dental office shall use Form 2, **Acknowledgement of Receipt of Notice of Privacy Practices**, found in this Privacy Kit, to obtain the Acknowledgement. If we cannot obtain written Acknowledgement from the patient, we will use the form to document our attempt and the reason why written Acknowledgement was not signed by the patient.

10. Patients' Rights

Our dental office will honor the rights of patients regarding their PHI.

a) Access – With rare exceptions, our dental office must permit patients to request access to the PHI we or our **Business Associates** hold.

No PHI will be withheld from a patient seeking access unless we confirm that the information may be withheld according to the Privacy Rules. We may offer to provide a summary of the information in the chart. The patient must agree in advance to receive a summary and to any fee we will charge for providing the summary. Our dental office will contact our **Business Associates** to retrieve any PHI they may have on the patient.

b) Amendment – Patients have the right to request to amend their PHI and other records for as long as our dental office maintains them.

Our dental office may deny a request to amend PHI or records if: (a) we did not create the information (unless the patient provides us a reasonable basis to believe that the originator is not available to act on a request to amend); (b) we believe the information is accurate and complete; or (c) we do not have the information.

Our dental office will follow all procedures required by the Privacy Rules for denial or approval of amendment requests. We will not, however, physically alter or delete existing notes in a patient's chart. We will inform the patient when we agree to make an amendment, and we will contact our **Business Associates** to help assure that any PHI they have on the patient is appropriately amended. We will contact any individuals whom the patient requests we alert to any amendment to the patient's PHI. We will also contact any individuals or entities of which we are aware that we have sent erroneous or incomplete information and who may have acted on the erroneous or incomplete information to the detriment of the patient.

When we deny a request for an amendment, we will mark any future disclosures of the contested information in a way acknowledging the contest.

c) Disclosure Accounting – Patients have the right to an accounting of certain disclosures our dental office made of their PHI within the 6 years prior to their request. Each disclosure we make, that is not for treatment payment or healthcare operations, must be documented showing the date of the disclosure, what was disclosed, the purpose of the disclosure, and the name and (if known) address of each person or entity to whom the disclosure was made. The **Authorization** or other documentation must be included in the patient's record. We use the patient's chart to track each disclosure of PHI as needed to enable us to fulfill our obligation to account for these disclosures.

We are not required to account for disclosures we made: (a) before April 14, 2003; (b) to the patient (or the patient's personal representative); (c) to or for notification of persons involved in a patient's healthcare or payment for healthcare; (d) for treatment, payment, or healthcare operations; (e) for national security or intelligence purposes; (f) to correctional institutions or law enforcement officials regarding inmates; or (g) according to an Authorization signed by the patient or the patient's representative; (h) incident to another permitted or required use disclosure.

We will temporarily suspend the accounting of any disclosure when requested to do so pursuant according to the Privacy Rules by health oversight agencies or law enforcement officials. We may charge for any accounting that is more frequent than every 12 months, provided the patient is informed of the fee before the accounting is provided. We will contact our **Business Associates** to assure we include in the accounting any disclosures made by them for which we must account.

d) Restriction on Use or Disclosure – Patients have the right to request our dental office to restrict use or disclosure of their PHI, including for treatment, payment, or healthcare operations. We have no obligation to agree to the request, but if we do, we will comply with our agreement (except in an appropriate dental/medical emergency).

We may terminate an agreement restricting use or disclosure of PHI by a written notice of termination to the patient. We will contact our **Business Associates** whenever we agree to such a restriction to inform the **Business Associate** of the restriction and its obligations to abide by the restriction. We will document in the patient's chart any such agreed to restrictions.

e) Alternative Communications – Patients have the right to request us to use alternative means or alternative locations when communicating PHI to them. Our dental office will accommodate a patient's request for such alternative communications if the request is reasonable and in writing.

Our dental office will inform the patient of our decision to accommodate or deny such a request. If we agree to such a request, we will inform our Business Associates of the agreement and provide them with the information necessary to comply with the agreement.

f) Applicability – Our dental office will be aware of and respect these patients' rights regarding their PHI, even though in most situations patients are unlikely to exercise them.

11. Staff Training and Management, Complaint Procedures, Data Safeguards, Administrative Practices

a) Staff Training and Management

*** Training** – Our dental office will train all members of our workforce in these Privacy Policies & Procedures, as necessary and appropriate for them to carry out their functions. We will complete the privacy training of our existing workforce by April 14, 2003.

Form 7, **Staff Review of Policies and Procedures**, can be used to have workforce members acknowledge they have received and read a copy of these Policies and Procedures.

***Discipline and Mitigation** – Our dental office will develop, document, disseminate, and implement appropriate discipline policies for staff members who violate our Privacy Policies & Procedures, the Privacy Rules, or other applicable federal or state privacy law.

Staff members who violate our Privacy Policies & Procedures, the Privacy Rules or other applicable federal or state privacy law will be subject to disciplinary action, possibly up to and including termination of employment.

b) Complaints – Our dental office will implement procedures for patients to complain about our compliance with our Privacy Policies and Procedures or the Privacy Rules. We will also implement procedures to investigate and resolve such complaints.

The **Complaint** form can be used by the patient to lodge the complaint. Each complaint received must be referred to management immediately for investigation and resolution. We will not retaliate against any patient or workforce member who files a **Complaint** in good faith.

c) Data Safeguards – Our dental office will "add to" and strengthen these Privacy Policies & Procedures with such additional data security policies and procedures as are needed to have reasonable and appropriate administrative, technical, and physical safeguards in place to ensure the integrity and confidentiality of the PHI we maintain.

Our dental office will take reasonable steps to limit incidental uses and disclosures of PHI made according to an otherwise permitted or required use or disclosure.

d) Documentation and Record Retention – Our dental office will maintain in written or electronic form all documentation required by the Privacy Rules for six years from the date of creation or when the document was last in effect, whichever is greater.

e) Privacy Policies & Procedures – Only Dr. James Snow may change these Privacy Policies & Procedures.

12. State Law Compliance

Our dental office will comply with the privacy laws of each state that has jurisdiction over our practice, or its actions involving protected health information (PHI), that provide greater protections or rights to patients than the Privacy Rules.

13. HHS Enforcement

Our dental office will give the U.S. Department of Health and Human Services (HHS) access to our facilities, books, records, accounts, and other information sources (including individually identifiable health information without patient authorization or notice) during normal business hours (or at other times without notice if HHS presents appropriate lawful administrative or judicial process).

We will cooperate with any compliance review or complaint investigation by HHS, while preserving the rights of our practice.

14. Designated Personnel

Our dental office will designate a Privacy Officer and other responsible persons as required by the Privacy Rules.

Pacific Dental Center

James A. Snow, DDS, INC.

Acknowledgement of Receipt of Notice of Privacy Practices

I _____ acknowledge that I have received a copy of Pacific Dental Center, James A. Snow, DDS, INC.'s Notice of Privacy Practices. This Notice describes how James A. Snow, DDS, Inc. may use my healthcare information, and rights I may have regarding my protected health information.

_____

(Signature of Patient, or Personal Representative)

_____

(Date)

_____

(Relationship to Patient)

Oral Cancer Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to rise. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major pre-disposing risk factors, but, **more that 25% of oral cancer victims have no such lifestyle risk factors.** There has also been a strong association of risk in young, non-smoking individuals if they carry the Human Papilloma Virus (HPV), which is the virus responsible for more than 95% of all cervical cancer. The concern with these individuals is that they may not even know that they are carrying the virus as there are no symptoms. Oral cancer risk by patient profile is as follows:

Increased risk: Patients ages 18-39
High risk: Patients age 40 and older; tobacco users
(any age, any type within 10 years)
Highest risk: Patients age 40 and older with lifestyle risk factors
(tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated the ***VELscope Oral Cancer Screening System*** into our oral screening standard of care. We find that using the VELscope along with a standard oral cancer examination improves our ability to identify suspicious areas at their earliest stages. The VELscope System is similar to proven early-detection procedures for other cancers such as mammography, Pap smear, and PSA. The VELscope examination is simple and painless and gives us the best chance to find any oral abnormalities at the earliest possible stage. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. This exam will be offered to you bi-annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT procedure code D0431; *however this exam may not be covered by your insurance*. The billable fee for the VELscope examination is $57. WE are dedicated to the overall wellbeing of our patients are convinced of the importance of the VELscope examinations in detecting oral cancer examination.

YES. I authorize Dr. Snow to perform the VELscope Oral Cancer Screening Exam in addition to the standard oral examination. I accept financial responsibility for this enhanced examination ($57.)

Print name: _____

Signature: _____ Date:_____

NO: I would prefer not to have the VELscope Oral Cancer Examination at this time.

Print name: _____

Signature: _____ Date: _____

Sleep Health Questionnaire

☐ M ☐ F / /

Patient Name | Gender | DOB

Address, City, State | Zip

Cell Phone | Alt. Phone | Email

Medical Insurance Company | ID# | Group#

FOR PATIENT USE

Patient Sleepiness Scale (Risk Factors): *Please check all that apply.*		pt.	*Additional comments below:*
1. I have been told I stop breathing while asleep	☐	8	
2. I have fallen asleep or nodded off while driving	☐	6	
3. I've woken up with shortness of breath / gasping or my heart racing	☐	6	
4. I feel excessively sleepy or fatigued during the day	☐	4	
5. I snore or have been told that I snore	☐	4	
6. I have had weight gain and found it difficult to lose	☐	4	
7. I have been diagnosed with high blood pressure	☐	4	
8. It takes me less than 10 minutes to fall asleep	☐	4	
9. I wake up more than 1 time per night	☐	4	
10. I wake up with headaches	☐	4	

Total points from above _____ .Check your Risk Level Score: ☐ **Low:** *0-7* ☐ **Moderate:** *8-11* ☐ **High:** *12-15* ☐ **Severe:** *16+*

FOR OFFICE USE

FOR PATIENT USE

Patient Health History (Signs & Symptoms): *Please check all that apply.*

- ☐ Snoring
- ☐ Depression/Anxiety
- ☐ Unrefreshed Upon Waking
- ☐ Witnessed Choking/Gasping/Apnea
- ☐ Irritability/Moodiness
- ☐ Wakes Up with Dry Mouth
- ☐ Sinus/Allergy Issues
- ☐ Grind Teeth
- ☐ Diabetes
- ☐ History of Stroke/Heart Disease
- ☐ Acid Reflux/GERD
- ☐ Hypertension
- ☐ Memory Loss
- ☐ Family History of OSA/Snoring
- ☐ Deviated Septum
- ☐ Currently Not Using Prescribed CPAP

Ask your dentist to complete.

- ☐ BMI > 30 (see reverse)
- ☐ Narrow upper arch
- ☐ Visual airway obstruction
- ☐ Large/scalloped tongue
- ☐ Neck size: Male ≥ 17" or Female ≥ 16"

_____ ' _____ "
Height

_____ lbs
Weight

_____ inches
Neck Size

_____
Blood Pressure

_____ BPM
Heart Rate

_____
BMI

I authorize this practice to release any medical information for the purpose of the coordination of care.

Patient Signature **Date**

FOR OFFICE USE

Prescription / Statement of Medical Necessity

*Certain insurance payers require a minimum **Risk Level Score of High** and/or **at least two (2) Signs & Symptoms**; sometimes up to four (4).*

Home sleep study (*G47.33 to be used to rule out OSA, unless stated differently. If other, please specify):* _____

- ■ **Baseline 2-Night or (_____-Night) home sleep study**
- ☐ **Assessment of oral appliance efficacy**
  - ☐ Redeem MYTAP™ Trial Appliance ("Love At First Bite")

I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

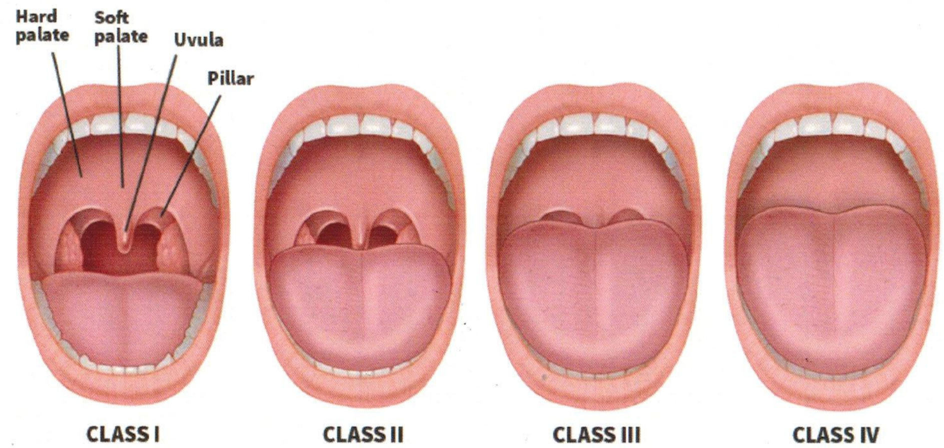
Pacific Dental Center
Dr. James A. Snow, DDS
156 N El Camino Real,
Encinitas, CA 92024
NPI#: 1275560658
Office Contact: Sue
Phone: (760) 436-7222
docsnowrays@aol.com

AS

Dr. Signature State Lic#: 40730 **Date** Account Code

Mallampati Score & BMI Chart

Visual Obstruction and Body Mass Index Reference Sheet



	Normal						Overweigh					Obese					Extreme Obesity																			
BMI (kg/m2)	19	20	21	22	23	24	25	t 26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	Weight (pounds)																																			
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

EzSLEEP™ In-Home Testing

Fax: 888-793-3903 • OrderEntry@EzSleepTest.com • Phone: 888-240-7735

Fax or email completed frontside form with copies of ID & medical insurance cards