Welcome To Our Office

Dear New Patient,

Thank you for choosing Dr. Unzicker's office. The doctors and staff are excited to meet you. We at Dr. Unzicker's strive to make every appointment as pleasant and enjoyable as possible. We know that choosing a dentist can be daunting, but are confident that we will be able meet your dental needs.

Established in 1982, Dr. Duane Unzicker started the practice based on a foundation of high quality dentistry in an open and honest environment. Duane's wife Gloria has been managing the dental office since the very beginning and is always available to assist our patient's needs. This family owned and operated dental practice grew once again in 2013 when Dr. Daniel Unzicker joined the practice. The blend of the father and son dental styles have been a great asset to the practice. With this addition, Dr. Unzicker's office will continue to provide honest, quality dentistry for decades to come.

We pride ourselves in specially reserving the doctor's time, as well as our qualified dental assistant's time, for each appointment. We make a point to not double book our patients so that we can provide the best service in a timely manner to all of our patients. Therefore, a missed appointment negatively affects our business, which in turn, can affect the level of care we are committed to providing to all our valued patients. We understand life brings the occasional circumstance that can cause a missed appointment, but we do assess a fee of $80 for missed appointments without adequate notice.

Attached is the new patient packet. Please fill it out to the best of your ability in order to facilitate a smooth first dental experience. Feel free to contact us with any questions you might have. We look forward to providing you with a very pleasant dental experience.

Sincerely,

Dr. Unzicker's Dental Team

PATIENT REGISTRATION AND MEDICAL HISTORY

Home Phone: _____

Date: _____ Cell Phone: _____

Patient: _____
Last Name First Name Middle Preferred Name

Street Address_____City_____State_____ Zip_____

Mailing Address_____City_____State_____Zip_____

Sex: ___M ___F Age _____ Birthdate _____ ___Single ___Married ___Widowed ___Divorced

Employed by _____Occupation _____

Business Address_____Business Phone_____

Spouse/Parent Name_____Spouse/Parent Birthdate_____

Spouse/Parent Employed by _____Occupation _____

Business Address_____Business Phone_____

Who is responsible for this account?_____Relationship to patient_____

Subscriber's Social Security # or Insurance ID #_____ Secondary SSN/ID #_____

Name of Dental Insurance Company_____ Group Number_____

In case of emergency, who should be notified?_____Relation_____Phone_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name_____Date of Last Physical_____

Is your general health good? ___Yes ___No

If no, explain: _____

Has there been a change in your health within the last year? ___Yes ___No

If yes, explain: _____

Have you been hospitalized in the last three years? ___Yes ___No

If yes, explain: _____

Have you had problems with prior dental treatment? ___Yes ___No

If yes, explain: _____

Are you experiencing any dental pain now? ___Yes ___No

If yes, explain: _____

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
___	___	Heart attack	___	___	Seizures/Epilepsy	___	___	Sinus Problems
___	___	Stroke	___	___	Respiratory Disease	___	___	Headaches
___	___	Artificial heart valve	___	___	Tuberculosis	___	___	Eating Disorders
___	___	Prosthetic joint	___	___	Heart Disease	___	___	Back problems
___	___	Heart defects	___	___	Liver Disease	___	___	Ulcer
___	___	Endocarditis	___	___	Kidney Disease	___	___	High cholesterol
___	___	High blood pressure	___	___	Nervous Problems	___	___	Thyroid Disease
___	___	Low blood pressure	___	___	HIV/AIDS	___	___	Cold Sores
___	___	Head/Neck Radiation	___	___	Leukemia/Blood Disease	___	___	Psychiatric Care
___	___	Cancer/Tumors	___	___	Organ transplants	___	___	Diabetes
___	___	Chemotherapy	___	___	Hemophilia/Bleeding disorder	___	___	Hepatitis

Are you allergic to or had a reaction to any of the following?

Yes	No		Yes	No		Yes	No	
___	___	Penicillin	___	___	Ibuprofen	___	___	Metal

__ __ Aspirin __ __ Vicodin/Narcotics __ __ Valium/Sedatives
__ __ Latex Other: _____

Are you taking:

Yes	No		Yes	No		Yes	No	
__	__	Tobacco in any form	__	__	Alcohol	__	__	Recreational drugs
__	__	Blood thinning medications	__	__	Bisphosphonates (Fosamax)			

Please list any medications you are taking:_____

_____

Please list any surgical history with approximate dates:_____

_____

(**Women**) Are you or could you be pregnant/nursing? ___Yes ___No
Are you taking birth control pills? ___Yes ___No

If the patient is a child, what is his/her weight? _____
Is there anything else we should know about your medical history? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ **Signature** _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)
and assigned directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Signature

MINOR/CHILD CONSENT

I, being the parent or guardian of _____do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to xrays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature of Insured/Guardian

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for the treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____

Date Signature of Insured/Guardian

Notice of Privacy Practices

This Notice describes how your health information 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
Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect July 14, 2016, 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 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. For more information about our privacy practices or additional copies of this Notice, please contact us (559) 584-2777.

Uses and Disclosures of Health Information

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

Treatment:
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment:
We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations:
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, 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 is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email:
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership:
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

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

Public Health:
We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

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 intel-

ligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders:
We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

Disclosure Accounting:
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

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 of how payments will be handled under the alternative means or location you request.

Breach Notification:
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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.

Questions and Complaints:
If you want more information about our privacy practices or have questions or concerns, please feel free to 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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I, [full name], have received a copy of Dr. Unzicker's Notice of Privacy Practices.

_____[Please Print Name]

_____[Signature]

_____[Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name

Relationship to Patient _____

For Program 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)