EndoLos Angeles
George B. Shinn Jr. DDS

ENDODONTICS PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Full Name _____ (First, Middle, Last) Patient is ☐ Male ☐ Female Patient's Birth Date _____ (Month/Day/Year)

Patient's Address _____ (Street) (City) (State) (Zip) Home Phone _____

Patient's Dentist _____ (Name) (City) Dentist's Phone _____

Whom may we thank for your referral? _____ Other family members seen by us? _____

RESPONSIBLE PARTY INFORMATION

Responsible Party 1 _____ (First, Middle, Last) (☐ Single ☐ Married ☐ Divorced) Relationship to Patient _____

Home Address _____ (Street) (City) (State) (Zip) Home Phone _____

Employer and Occupation _____ Birth Date _____ (Month/Day/Year) Social Security No. ___/___/___

E-mail Address _____ Work Phone _____ Cell Phone _____

Responsible Party 2 _____ (First, Middle, Last) (☐ Single ☐ Married ☐ Divorced) Relationship to Patient _____

Home Address _____ (Street) (City) (State) (Zip) Home Phone _____

Employer and Occupation _____ Birth Date _____ (Month/Day/Year) Social Security No. ___/___/___

E-mail Address _____ Work Phone _____ Cell Phone _____

Primary Insurance & Subscriber _____ Secondary Insurance & Subscriber _____

HEALTH HISTORY

MEDICAL HISTORY - Please check "Yes" or "No" to all items below

☐Yes ☐No ADHD/ADD (if so, what medication(s)? _____
☐Yes ☐No Asthma (if so, what medication(s)? _____
☐Yes ☐No Girls: Started menstruation? First Cycle: _____
☐Yes ☐No Boys: Voice changed?
☐Yes ☐No Heart Trouble/Murmur (if so, what medication(s)? _____
☐Yes ☐No Artificial Joints (If so, when?) _____
☐Yes ☐No Joint Swelling or Arthritis
☐Yes ☐No Prolonged Bleeding
☐Yes ☐No Endocrine Problems
☐Yes ☐No Diabetes
☐Yes ☐No Bone Disorders
☐Yes ☐No Hepatitis or Liver Problem
☐Yes ☐No Tuberculosis (TB)
☐Yes ☐No AIDS or HIV
☐Yes ☐No Epilepsy
☐Yes ☐No Tonsils Removed (If so, when?) _____
☐Yes ☐No Are you pregnant? How far along? _____
☐Yes ☐No Seasonal Allergies Meds: _____
☐Yes ☐No Drug Allergies Which Ones? _____
☐Yes ☐No Latex Allergies
☐Yes ☐No Nickel Allergy
☐Yes ☐No Nut Allergy

DENTAL HISTORY - Please check "Yes" or "No" to all items below

Date of last dental cleaning: _____

☐Yes ☐No Any injuries to ☐face, ☐mouth, ☐teeth?
☐Yes ☐No Thumb, finger or lip sucking habit(s)? Discontinued at age _____
☐Yes ☐No Mouth breathing when ☐awake, ☐asleep?
☐Yes ☐No Any known missing permanent teeth? _____
☐Yes ☐No Any known extra permanent teeth? _____
☐Yes ☐No Any teeth removed by extraction? If so, when _____
☐Yes ☐No A tongue thrust problem? ☐Speech problems?
☐Yes ☐No Any clenching or grinding of teeth? ☐Day ☐Night ☐Both
☐Yes ☐No Any pain, popping or locking on opening or closing jaw?
☐Yes ☐No Frequent headaches? If so, number per week _____ ☐AM ☐PM
☐Yes ☐No Any muscle tenderness or stiffness in the ☐jaw ☐neck?
☐Yes ☐No Any ☐ringing sounds in the ear or ☐spells of dizziness?
☐Yes ☐No Any previous treatment for TMJ or jaw point problems?
☐Yes ☐No Any previous orthodontic evaluation or treatment?
☐Yes ☐No Are you under doctor's care now?

For what? _____
Name of Physician: _____
Physician's Phone: _____

PLEASE LIST YOUR **CHIEF CONCERN(S)** AND WHAT YOU WOULD LIKE TREATMENT TO ACCOMPLISH:

_____

_____

Signature of Person Completing Form: _____ Date: _____

Updated Health History/ Personal Infomation:

Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Initials: _____	Initials: _____	Initials: _____	Initials: _____	Initials: _____

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SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone: (310) 649-3636
Address: 8540 S SEPULVEDA BLVD STE. 1200
LOS ANGELES, CA 90045

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: FOR OFFICE USE ONLY

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

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

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

PRIVACY PRACTICES RECEIPT / CONSENT FORM

EndoLos Angeles
George B. Shinn Jr. DDS

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Provide you with appointment reminders (such as voicemail messages, texts, postcards, or letters).

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

TO KNOW MORE INFORMATION:http://endlosangeles.com

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Organizations
This Notice of Privacy applies to all affiliated entities doing business as Great Expressions Dental Centers.

Contact

Working hours: 9am – 5pm on weekdays

Westchester Office: (310) 649-3636

info@EndodonticsLA.com

8540 S SEPULVEDA BLVD STE. 1200
LOS ANGELES, CA 90045

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION F: PATIENT/RELATIVE HIPAA CONSENT

I, _____ , understand that by signing this Consent form, I am giving my consent to Great Expressions Dental Centers to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: _____

Relationship: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

_____ _____

Patient's Signature (Legal Guardian, if Patient is a minor) Date:

SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)

I request Great Expressions Dental Centers restrict the disclosure of my PHI to those specified below:

Name: _____

Name: _____

Signature: _____ Date: _____

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____