(Office Use Only) MR#:_____

SYCUAN MEDICAL DENTAL CENTER

Patient Demographic Form

Name _____
Last First M.I.

Patient S.S. #: _____ - _____ - _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ /_____ /_____ Email Address: _____

Residence Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____ Apt# _____
(If different than Residence Address)

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ X: _____ Department: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact: _____

Relationship to Patient: _____Telephone # _____

Emergency Contact's Address: _____

If patient is a minor, please indicate Parent's/Guardian's information if different than Patient's Information.

Father's Name: _____ Telephone # _____

Father's Address: _____

Mother's Name: _____ Telephone # _____

Mother's Address: _____

Primary Insurance Co: _____ ID# _____ Grp# _____

Secondary Insurance Co: _____ ID# _____ Grp# _____

Policy Holder's Name: _____ ID# _____

Policy Holder's DOB: _____ / _____ / _____ Policy Holder's SS# _____ / _____ / _____

Policy Holder's Address: _____ Copay Amount $____

Please list the name(s) of a person(s) with whom we can share the patient's Protected Health Information, and who can pick up prescriptions, in the event you are unable to:
(If none, then write "None")

_____

_____

I hereby authorize and request the performance necessary for treatment using whatever procedures the judgement of the provider may dictate during my treatment.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(Office Use Only) MR#:_____

SYCUAN MEDICAL DENTAL CENTER

Patient Financial Form

Patient Legal Name _____ Register Date: ____ /____ /____
Last First M.I.

Patient S.S. #: ____ - ____ - ____ Date of Birth: ____ /____ /____ Spouse's Name: _____

Race/Ethnicity ___ American Indian/Alaskan Native
___ Asian/Pacific Islander
___ African American
___ Hispanic
___ White (Non-Hispanic)
___ Mixed/Other

If American Indian/Alaskan Native:
Tribe: _____
Tribal Enrollment # _____
Tribal Blood Quantum _____
Total AI/AN Blood Quantum _____

Occupation: _____ Name of Employer: _____

U.S. Veteran _____ Yes _____ No Service Branch: _____

Person Responsible for Payment: _____ Relationship: _____

Address: _____
Street City State Zip Phone #

(If applying for sliding scale)
Number of Persons in Household: _____ Annual Household Income: $_____

	Primary Medical Insurance	Secondary Medical Insurance
Subscriber:		
Relationship to Patient:		
Subscriber's Social Security #:		
Subscriber's Date of Birth:		
Subscriber's Employer:		
Subscribers Insurance Carrier:		
Subscriber's Carriers Phone #:		
Subscriber's Policy/Group #:		

Certification Statement: I certify that the information above is true and accurate to the best of my knowledge. I hereby assign all medical benefits to include major healthcare benefits to which I am entitled, including MediCal, Medicare, private insurance and any other health insurance plan to Sycuan Medical Dental Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

_____ _____
Name of Patient (Print) Date

_____ _____ _____
Name of Responsible Party (Print) Relationship to Patient Driver's License #

_____
Signature of Responsible Party

Revised June 12, 2018

SYCUAN MEDICAL DENTAL CENTER

General Consent for Dental Diagnosis and Treatment & Notice of Privacy Practices and Non-Discrimination Acknowledgment of Receipt

Consent for Treatment

The undersigned patient or responsible guardian of a minor patient consents to authorize our dentists or dental assistants who are under the general supervision of our dentists, to perform an examination and other diagnostic procedures deemed necessary to render proper dental care. By signing below the patient or responsible guardian of a minor patient acknowledge that the above statements have been read and that the consent for treatment and to receive medication from our healthcare providers is given.

_____ _____

Print Name of Patient of Personal Representative Date

_____

Signature of Patient (Or Patient's Parent/Conservator/Guardian/Personal Representative)

Notice of Privacy Practices and Non-Discrimination Acknowledgment of Receipt

By signing this form, you acknowledge your right to request to review the *HIPAA Notice of Privacy Practices and Non-Discrimination* of *Sycuan Medical Dental Center*. Our *HIPAA Notice of Privacy Practices and Non-Discrimination* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *HIPAA Notice of Privacy Practices and Non-Discrimination* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at: 619-445-0707. If you have any questions about our *HIPAA Notice of Privacy Practices and Non Discrimination*, please contact: The Privacy Officer: 5442 Sycuan Road, El Cajon, CA 92019, (619) 445-0707 x172, or bsandoval@sycuanmed.org.

I acknowledge my right to review the HIPAA *Notice of Privacy Practices and Non-Discrimination* of Sycuan Medical Dental Center.

_____ _____

Signature of Patient (Or Patient's Parent/Conservator/Guardian/Personal Representative) Date

(Office Use Only) MR#: _____

SYCUAN MEDICAL DENTAL CENTER

Consent for Treatment, Payment and Healthcare Operations & Notice of Privacy Practices and Non-Discrimination Acknowledgement of Receipt

I consent to the use of disclosure of my protected health information by the Sycuan Medical Dental Staff for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care and to conduct health care operations of the Sycuan Medical Dental Center. I understand that diagnosing and treatment of me by Sycuan Medical Dental staff may be conditioned upon my consent as evidence of my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is disclosed to carry out treatment, payment or health care operations of the practice. SMDC is not required to agree to the restrictions that I may request. However, if SMDC agrees to a restriction I request, the restriction is binding on the SMDC and its staff.

I have the right to revoke this consent, in writing, at any time, except to the extent that SMDC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, an employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition that identifies me, or there is a reasonable expectation that the information may identify me.

I understand I have a right to review SMDC's Notice of Privacy Practices and Non-Discrimination by signing this document. The SMDC's Notice of Privacy Practices and Non-Discrimination has been provided me. The Notice of Privacy Practices and Non-Discrimination describes the types of uses and disclosures of protected health information that will occur in my treatment, payment of my bills, or in the practices' health care operations of the SMDC. The Notice of Privacy Practices and Non-Discrimination of SMDC is also provided at 5442 Sycuan Road, El Cajon, CA 92019. The Notice of Privacy Practices and Non-Discrimination also describes my rights and the SMDC's duties in regards to my protected health information.

SMDC reserves the rights to change the privacy practices that are contained in its Notice of Privacy Practices and Non-Discrimination. I may obtain a revised Notice of Privacy Practices and Non-Discrimination that are outlined in The Notice of Privacy Practices and Non-Discrimination by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

If you have any questions about our *Notice of Privacy Practices and Non-Discrimination*, please contact*:*
The Privacy Officer: (619) 445-0707 x172

_____ _____
Signature of Patient (Or Patient's Parent/Conservator/Guardian/Personal Representative) Date

_____
Print Name of Patient or Personal Representative

Inability to Obtain Acknowledgement: *(To be completed only if no signature is obtained.)*
If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____ _____
Signature of Provider Representative Date

Revised: June 12, 2018

SYCUAN MEDICAL DENTAL CENTER

Adult General Health Review

(Office Use Only) MR#:_____

Name _____ Date _____

Date of Birth _____ Age _____ Sex: ☐ Male ☐ Female Race _____

Occupation _____x Yrs? ____ Check One: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Allergies to Medications _____

If so, type of reaction? _____

Medications You Take:	Strength	Frequency

Date of Last:

TB skin test _____ Result _____ Tetanus shot _____ EKG _____
Chest X ray _____ Hepatitis vaccines _____ Flu vaccine _____
Pneumonia vaccine _____ Cholesterol test _____ Dental Exam _____ Eye Exam _____
Date and Type of Hospitalizations/Surgeries: _____

Please check yes if you have had any of the following conditions:

Yes	No		Yes	No		Yes	No	
☐	☐	Alcohol abuse	☐	☐	Arthritis	☐	☐	Cancer
☐	☐	Cardio/Respiratory	☐	☐	Convulsions/Epilepsy	☐	☐	High Blood pressure
☐	☐	Glaucoma	☐	☐	Heart disease	☐	☐	Rheumatic fever
☐	☐	Kidney disease	☐	☐	Liver disease	☐	☐	Diabetes: Date diagnosed?
☐	☐	Transfusions	☐	☐	TB			____/____/____
☐	☐	Other _____						

Please check yes if family has a history of any of the following conditions:

Yes	No		Yes	No		Yes	No	
☐	☐	Alcohol abuse	☐	☐	Arthritis	☐	☐	Cancer
☐	☐	Cardio/Respiratory	☐	☐	Convulsions/Epilepsy	☐	☐	Diabetes
☐	☐	Glaucoma	☐	☐	Heart disease	☐	☐	High Blood pressure
☐	☐	Kidney disease	☐	☐	Liver disease	☐	☐	Rheumatic fever
☐	☐	Transfusions	☐	☐	TB	☐	☐	Other _____

Mother living? ___ Age___ or deceased what age? ____ Father living? ___ Age ___ or deceased what age? ___
List any siblings & living/age or deceased what age: _____

Social History

Do you smoke and how many packs per day? _____ Other tobacco use? _____
Recreational drug use? _____ Alcohol use? _____
Regular seatbelt use? _____ Regular exercise? _____ Type? _____
HIV risk assessment? _____ Exposure to domestic violence? _____

Females Only

Date of Last:
Pap smear _____ History of abnormal Pap _____ Breast Exam _____
Mammogram _____ Date of onset of last period _____ Length of period _____
# of Days in cycle _____ Practice Self Breast Exams _____
# of pregnancies _____ # of miscarriages _____ # of living children _____
Type of birth control _____ Condom use? _____

Yes / No

☐ ☐ Have you ever felt the need to **cut** down on your drinking?
☐ ☐ Have people **annoyed** you by criticizing your drinking?
☐ ☐ Have you ever felt bad or **guilty** about your drinking?
☐ ☐ Have you ever needed a drink first thing in the morning to steady your nerves or get rid of a hangover?

Tolerance: _____ How many drinks does it take to get high?

(Office Use Only Within this box)

☐ **CAGE Questionnaire** (for child bearing women only between the age of 15 and 44)
Based on how many YES answers were received, document Health Factor on PCC (e.g., CAGE 0/4 = all NO answers). Quantity: # of drinks daily or tolerance - # drinks to get high (e.g., T-4).
End Result:_____

Please ***check*** if you have ever had any of the following symptoms and ***circle*** **current symptoms**:

General

Yes No

☐ ☐ Weight gain/loss > 10 lb.
☐ ☐ Recurrent fever, sweats
☐ ☐ Swollen glands
☐ ☐ Headaches, fatigue
☐ ☐ Nutritional questions
☐ ☐ Diet concerns

Skin

☐ ☐ Rashes, eczema
☐ ☐ Changes in warts, moles, lumps
☐ ☐ itching, bruising, hives

Eyes

☐ ☐ Change in vision

Ears

☐ ☐ Change in hearing
☐ ☐ Infection

Nose

☐ ☐ Frequent bleeding
☐ ☐ Sinus trouble

Throat / Oral

☐ ☐ Hoarseness
☐ ☐ Difficulty swallowing
☐ ☐ Frequent sore throats
☐ ☐ Teeth, gums, dental problems, TMJ

Endocrine / Metabolism

Yes No

☐ ☐ Hormonal problems
☐ ☐ Goiter, thyroid problem

Neurological

☐ ☐ Convulsions, fainting spells
☐ ☐ Numbness, tingling
☐ ☐ Paralysis
☐ ☐ Shakes, tremors

Musculoskeletal

☐ ☐ Muscle or joint pain
☐ ☐ Back pain

Blood / Lymph

☐ ☐ Bleeding, anemia
☐ ☐ Swollen lymph nodes

Gi / Liver

☐ ☐ Change in bowel habits
☐ ☐ Black / bloody stool
☐ ☐ Diarrhea
☐ ☐ Constipation, hemorrhoids
☐ ☐ Indigestion, heartburn
☐ ☐ Ulcers
☐ ☐ Jaundice
☐ ☐ Hernia
☐ ☐ Nausea / vomiting

Psychological

☐ ☐ Depression, suicidal thoughts
☐ ☐ Anxiety, nervousness

Cardio / Respiratory

Yes No

☐ ☐ Frequent cough
☐ ☐ Difficulty breathing
☐ ☐ Wheezing, asthma
☐ ☐ Bringing up sputum or blood
☐ ☐ Palpitations / Irregular heart beat
☐ ☐ Pain / Pressure in chest
☐ ☐ Contact with tuberculosis
☐ ☐ Swelling of feet or ankles
☐ ☐ Previous heart trouble / murmurs
☐ ☐ High blood pressure
☐ ☐ Varicose veins

Kidney / Urological

☐ ☐ Frequent / difficult urination
☐ ☐ Burning / blood in urine
☐ ☐ Discharge or sores on genitals
☐ ☐ Kidney stones

Breast

☐ ☐ Lumps, discharge

Women: Gynecological

☐ ☐ Irregular or frequent periods
☐ ☐ Excessive flow or spotting
☐ ☐ Vaginal discharge or itching
☐ ☐ Painful periods

Other

☐ _____

SYCUAN MEDICAL DENTAL CENTER

Screening for Aerosol Transmissible Diseases (ATD)

In compliance with Sycuan Medical Dental Center (SMDC) policy, dental procedures are not performed at the SMDC on patients suspected or identified as having aerosol transmissible diseases.

Circle all that apply:

Do you have a history of tuberculosis or symptoms of tuberculosis?		**Yes**	**No**
Productive Cough	Malaise		
Bloody sputum	Night sweats		
Fever	Unexplained weight loss		

Do you have any of the following aerosol transmissible diseases?		**Yes**	**No**
Influenza (flu)	Chicken Pox		
Pertussis	Meningitis		
Measles	Rubella		
Mumps			

Do you have symptoms of any aerosol transmissible diseases?		**Yes**	**No**
Body aches	Fever		
Runny Nose	Difficulty breathing		
Nausea	Coughing spasms		
Vomiting	Painful swollen glands		
Diarrhea	Skin rashes or blistering		

Do you have any of the following chronic respiratory diseases?		**Yes**	**No**
Bronchitis	Emphysema		
Allergies	Asthma		
Chronic upper airway cough syndrome-post nasal drip			
Chronic obstructive pulmonary disease (COPD)			
Gastroesophageal reflux disease (GERD)			

Chronic respiratory diseases are NOT aerosol transmissible diseases and do not disqualify a patient from receiving dental treatment.

_____ _____

Patient's Name (Print) Date

_____

Patient's Signature

(Office Use Only) MR#: _____

SYCUAN MEDICAL DENTAL CENTER

Advance Health Care Directive Questionnaire Acknowledgement

Patient Name: _____

Social Security #: _____ Date of Birth: _____

Please read and initial the following five statements:

_____ I have been given written materials about my right to accept or refuse medical treatment.

_____ I have been informed that I am not required to formulate Advance Directives.

_____ I understand that I am not required to formulate Advance Directives.

_____ I understand that I am not required to have an Advance Directive in order to receive medical treatment at this office.

_____ I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to extent permitted by law.

Please check one of the statements below & complete applicable information:

☐ Yes, I have executed/completed an Advance Health Care Directive packet (7 page Legal document). It is filed at the office(s) of:

_____

☐ No, I have not executed/completed an Advance Health Care Directive packet (7 page Legal document).

Signed: _____ Date: _____

Witness: _____ Date: _____