



Dr. Miriam Zuniga Bernardeau
D.D.S.
14349 Woodruff Ave.
Bellflower CA 90706
P. (562) 455-1717
F. (562) 455 1718

PATIENT INFORMATION FOR DOCTOR'S RECORD

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. This information is necessary for our files and your health, and will be considered **CONFIDENTIAL**

PATIENT'S FIRST NAME _____ PATIENT'S LAST NAME _____

Who is financially responsible for this bill? FIRST NAME _____ LAST _____

HOME ADDRESS _____ CITY _____ ZIP _____ YEARS LIVED HERE? _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____ EXTENSION _____

PATIENT'S BIRTHDATE ____ / ____ / ____ AGE ____ MR. ____ MRS. ____ MISS ____ MS. ____
Month Day Year

HEIGHT _____ WEIGHT _____

MARITAL STATUS (check) Single ____ Married ____ Widowed ____ Divorced ____ SEX: Male ____ Female ____

Whom may we thank for referring you to our office? _____ Yellow Pages? _____

YOUR EMPLOYER _____ OCCUPATION _____ YEARS WITH FIRM _____

EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____

DRIVER'S LICENSE # _____ SOCIAL SECURITY # _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____ Years there _____

SPOUSE'S EMPLOYER'S ADDRESS _____ CITY _____ ZIP _____

SPOUSE'S EMPLOYER'S PHONE (_____) _____ EXTENSION _____ SPOUSE'S SOCIAL SECURITY # _____

FOR PATIENTS WITH DENTAL INSURANCE:

INSURED PERSON'S NAME _____ SOC. SEC. # _____ BIRTHDATE _____

NAME OF INSURANCE PLAN _____ PLAN or POLICY # _____ UNION LOCAL # _____

How much is your deductible? _____ How much, if any, have you satisfied? _____

Does your spouse also have dental insurance? _____ (If yes, please give us the following:)

SPOUSE'S SOC. SEC. # _____ BIRTHDATE _____ NAME OF PLAN _____

PLAN # _____ LOCAL # _____ IS PATIENT COVERED BY BOTH INSURANCE PLANS? _____

Email: _____

CONSENT FOR TREATMENT

I hereby grant authority to Dr. Zuniga and/or the other dentist(s) in this office, in charge of the care of the patient whose name appears on this form above to: administer or prescribe any dental or emergency treatment: and to administer such medicines, aesthetics, analgesics, sedatives, antibiotics, etc.: and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I accept complete financial responsibility and agree to pay for such services in full.

LEGAL SIGNATURE _____ DATE _____

Health Questionnaire

Nearest relative not living with you in case of Emergency

NAME

ADDRESS

CITY

Please answer each question, circle yes or no where applicable

MEDICAL HISTORY

1. Are you in good health? YES NO
2. Date of last physical examination YES NO
3. Are you now under the care of a physician? YES NO
If so, what is the condition being treated?
4. Have you ever had any serious illness or operation? YES NO
If so, what illness or operation?
5. Have you ever been hospitalized? YES NO
If so, what was the problem?
6. Are you taking any drugs or medicine? YES NO
If so, what
7. Are you sensitive or allergic to any drugs? YES NO
If so, what
8. Have you taken Phen-fen? YES NO
9. Do you have, or have you had any of the following YES NO

Anemia YES NO	Blood Disease YES NO	Knee or Hip Replacement Surgery YES NO
Heart Aliments YES NO	Hepatitis, jaundice or liver disease YES NO	Rheumatism or Arthritis YES NO
High Blood Pressure YES NO	Kidney Disease YES NO	Head Injuries YES NO
Respiratory Disease YES NO	Tumors or Growths YES NO	Stomach Ulcers YES NO
Tuberculosis YES NO	Radiation treatment of any kind YES NO	Venereal Disease YES NO
Nervous Disorder YES NO	Allergies YES NO	Epilepsy YES NO
Diabetes YES NO	Asthma or Hay fever YES NO	Mental Disorders YES NO
Excessive Bleeding YES NO	Fainting spells or seizures YES NO	Stroke YES NO
Rhematic Fever YES NO	Sinus trouble YES NO	Positive Test to HIV YES NO
	Allergy to Latex YES NO	Acquired Immune Deficiency Syndrome YES NO
		Mitral Valve Prolapse YES NO
10. Do you wear a cardiac peacemaker? YES NO
11. Have you had heart surgery? YES NO
12. Do you have any disease, condition or problem not listed above that you think I should know about? YES NO
If so, explain
13. (Women) Are you pregnant? YES NO
14. (Women) Do you have any problem associated with your menstrual period? YES NO
15. Are you currently taking aspirin on a daily basis? YES NO
16. Are you currently taking coumadin or any blood thinners? YES NO
18. Have you been Vaccinated? YES NO
If so, Dose Brand
19. Have you been in contact with someone with Covid? YES NO
20. Mental Disorders YES NO
If so, Specified

DENTAL HISTORY

21. Have you ever had a local anesthetic (Novocaine, etc.)? YES NO
22. Have you ever had any allergic reaction from local anesthetic? YES NO
23. Have you had any serious trouble associated with any previous dental treatment: YES NO
If so, explain
24. How long since last full Mouth X-rays?
25. How long since last Dental Treatment?
26. Does dental treatment make you nervous? YES NO
If yes, check: Slightly Moderately Extremely
27. Do you grind your teeth or hear your jaw clicking? YES NO
28. Do you have temporomandibular joint dysfunction (TMJ Syndrome) ? YES NO
29. Do you smoke or chew tobacco? YES NO
30. Pharmacy Information
Phone Number
City

Date	Patient Signature
Reviewed by (Dentist)	Date
Updated	Signature
Reviewed by (Dentist)	Date
Updated	Signature
Reviewed by (Dentist)	Date



Dr. Miriam Zuniga
14349 Woodruff Ave
(562) 455-1717

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THIS PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provide such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and in the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, Or for additional copies of this Notice, please contact us using the information at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to a physician or other healthcare provider pending treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provided to you.

Healthcare operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification licensing or credentialing activities.

Our 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 of disclosures permitted by your authorization while it was in effect. Unless you give us 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. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or 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 responsible inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we 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 the authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format your 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 using the contact information listed at the end of this Notice. 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 to the address at the end of this Notice. If you request copies, we will charge you for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative 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 using the information at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in 12- month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restrictions: 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 an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means, to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by Electronic mail (e-mail), you are entitled to receive this notice in written form.

If patient is under any type of managed care program and the facility is not notified; the patient will be responsible for the entire fee.

QUESTIONS AND COMPLAINTS

If you want more information on our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint to the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services

For more information about HIPAA or to file a complaint:
The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W., Washington, DC 20201
202/619-0257 or Toll free: 1/877-696-6775

ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY PRACTICES

Signature: _____
Date: _____

Consent for use and Disclosure of Health Information

Section A: Patient giving Consent

Name: _____

Address: _____

Telephone: _____

Social Security: _____

Section B : To the patient please read the following statements carefully

- ✚ Posted in our lobby is our *Notice of Privacy Practices*. It provides information about how our office may use and disclose your protected health information (PHI) :

You have the right to review our *Notice of Privacy Practices* before signing this patient consent form. Please take the time to do so now. A copy is attached

You have the right to request that we restrict how your PHI is used or disclosed for treatment billing/payment or Dental office operations. Request for restriction of PHI must be submitted to the OCP in writing and signed by you as specified in our notice;

- ✚ Our office does not have to agree with your request for restriction of PHI. If we agree to your request the ocp in writing and signed by you as specified in our notice;

You have the right to revoke this patient consent form. Revocation of consent must be submitted to the OCP in writing and signed by you as specified in our notice;

- ✚ A revocation of consent, does not affect disclosure made prior to the date the revocation was made.
- ✚ Our notice of privacy practices may change from time to time. If it does, you will receive a revised notice on the first visit after changes to the notice were made.
- ✚ Your signature below signifies your consent to the use and disclosure of your PHI by our office during treatment billing/payment , dental office operation as outlined in our notice
- ✚ Our office may condition dental treatment upon execution of this patient consent form.
- ✚ This form is provided to you so that our office may comply with the health insurance portability and accountability act of 1996 (HIPPA)

You may obtain a copy of our notice of privacy practices including any revisions of our notice, at any time by contacting:

Contact Person: Miriam Zuniga

Telephone Number: (562) 455-1717 Fax: (562) 455-1718

Email: dr.zuniga@amazingfamilysmile.com

Address: 14349 Woodruff Ave. Bellflower CA, 90706

Section C: signature

Signature: _____

If this consent is signed by a personal representative on behalf of the patient,. Complete the following:

Personal representative name : _____

IMPORTANT MEDICAL ALERT

A connection between Fosomax, and other bisphosphonates with a serious bone disease called Osteonecrosis of the Jaw (ONJ) has been found.

Bisphosphonates are commonly used in tablet form to prevent and treat osteoporosis in post-menopausal women. They are also used in the treatment of Paget's disease. Stronger forms given orally or intravenously (IV) are commonly used in the management of advanced cancers including, but not limited to, lung cancer, breast cancer, prostate cancer, and multiple myeloma.

Have you ever taken or currently taking any of the following bisphosphonates?

Y N Alendronate (Fosomax)

Y N Clodronate (Bonefos, Ostac)

Y N Etidronate (Didronel)

Y N Ibandronate (Bonival)

Y N Pamidronate (Aredia)

Y N Raloxifine (Evista)

Y N Risedronate (Actonel)

Y N Teriparatide (Forteo)

Y N Tiludronate (Skelid)

Y N Zoledronate (Zometa)

If yes, when?

Prescribing Doctor:

Name

Phone

Signature:

Print Name: _____ Date: _____

MISSED APPOINTMENTS AND CANCELLATION POLICY

EFFECTIVE JUNE 1, 2018

APPOINTMENT POLICY

Amazing Smile Family Dental will work with you to schedule appointment times that are convenient for you. Because we do not overbook patients in anticipation of no-shows or last minute cancellations, it is important that you keep scheduled appointments. We understand that illness, emergencies, flat tires, and bad weather do occur. We require patients to give 24 hour notice whenever possible if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting. We attempt to remind patients by telephone, email, and/or text messaging prior to upcoming appointments, but please do not depend on this courtesy. If we are unable to reach you, your appointment card will serve as confirmation of your appointment and implies your obligation to be present. We reserve the right to charge for appointments canceled or broken without 24 hours advance notice (see below). We strive to see patients on time for scheduled appointments. However, there are times when our schedule is delayed in order to accommodate an emergency or complication in a scheduled procedure. Please accept our apology should this occur during your appointment.

CANCELLATION POLICY : We require you to notify us of any cancellation at least 24 hours prior to your appointment. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule.

CANCELLATION/MISSED APPOINTMENT POLICY AND FEES

A fee of \$150 will be charged to the patient's account for CANCELLATION/MISSED Appointments. A

CANCELLATION/MISSED Appointment is when the patient: • cancels or reschedules with less than 24 hours notice. • Fails to show up for the appointment.

RESERVING LONG APPOINTMENT TIMES

Due to the extensive amount of time our staff, hygienists and doctors devote to preparing and reserving uninterrupted time for long appointments, we require a deposit to make your reservation. This deposit is not an additional cost, unless the patient incurs a Broken Appointment. **We reserve the right to keep the deposit if the patient cancels or misses the appointment, and further require an additional deposit to reschedule the appointment.**

Dentist deposit - \$200 • All appointments 2 or more hours in length • All I.V. sedation appointments

X_____ I UNDERSTAND