Anita B. Youngblood DMD Inc.

Cosmetic & General Dentistry

180 Montgomery Street, Suite 2450
San Francisco, California 94104
Phone: (415) 433-4912
Fax: (415) 433-2859
anita_youngblood@yahoo.com

Welcome to Our Practice

We are delighted that you have chosen our office to provide your dental care. To help you feel more comfortable and at home, we have provided you with some information about your first visit to our office.

- We schedule carefully to avoid having you wait. Your time is very valuable to us and we will always treat it with respect.
- Dr. Youngblood will meet with you, one on one to discuss your dental needs and wishes
- A complete oral examination will be given to determine the type of cleaning appropriate for you. We have found that prevention is the key to healthy teeth and gums.
- Diagnostic films will be taken, if needed, on this appointment to evaluate decay, bone loss, and soft and hard tissue lesions.
- Filling out the enclosed paperwork before you arrive in the office will assist in making your visit run as smoothly and quickly as possible.
- If for some reason you cannot keep your reserved time, please give us 24 hours notice so that we can offer the time to another patient. A $75.00 charge will be applied to any appointment that is cancelled within a 24-hour period.

Our entire team is dedicated to your well being. We are enthusiastic about what dentistry can offer everyone. We are committed to bringing the highest level of care and professionalism possible.

If there are any questions you might have before your reserved time with us, please don't hesitate to call. Thank you again for choosing our office.

Sincerely,

Dr. Youngblood and Staff

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Welcome to Our Practice

Personal Information

Date: _____

Patient: _____ _____
First Name M.I. Family Name Nickname

Referred By: _____

Sex: _____ Date of Birth: _____ Age: _____ SS/: _____

Home Address

_____
Street City State Zip

Email Address: _____

Home Phone : (_____)_____ Work Phone : (_____)_____ Ext _____

Mobile Number: (_____)_____

Employer: _____ Occupation: _____

Are you a student? _____ If so, what school do you attend?_____

Marital Status: _____

Who will be responsible for your account? (Check one):

☐ **Self** ☐ **Spouse** ☐ **Parents** ☐ **Others: _____**

Name of Dental Insurance : _____

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HEALTH HISTORY

Patient Name: _____ **Birth Date:** _____

I. CIRCLE APPROPRIATE ANSWERS (Leave Blanks if you do not understand questions):

1 Yes No Is your general health good?

2 Yes No Has there been a change in your health within the last year?

3 Yes No Have you been hostpitalized or had a serious illness in the last 3 years? If Yes, Why? _____.

4 Yes No Are you being treated by a physician now? For What? _____.

5 Yes No Have you had problem with prior dental treatment?

6 Yes No Are you in pain now?

Date of last medical exam? _____. Date of last Dental Exam? _____.

II. HAVE YOU EXPERIENCED:

7	Yes	No	Chest Pain (angina)?	18	Yes	No	Dizziness?
8	Yes	No	Swollen ankles?	19	Yes	No	Ringing in ears?
9	Yes	No	Shortness of breath?	20	Yes	No	Headaches?
10	Yes	No	Recent weight loss, fever, night sweats?	21	Yes	No	Fainting spells?
11	Yes	No	Persistent cough, coughing up blood?	22	Yes	No	Blurred vision?
12	Yes	No	Bleeding problems, bruising easily?	23	Yes	No	Seizures?
13	Yes	No	Sinus problem?	24	Yes	No	Excessive thirst?
14	Yes	No	Difficulty swallowing?	25	Yes	No	Frequent urination?
15	Yes	No	Diarrhea, constipation, blood in stool?	26	Yes	No	Dry mouth?
16	Yes	No	Frequent vomiting, nausea?	27	Yes	No	Jaundice?
17	Yes	No	Difficulty urinating, blood in urine?	28	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU EVER HAD:

29	Yes	No	Heart disease?	41	Yes	No	AIDS/HIV
30	Yes	No	Heart attack, heart deffects?	42	Yes	No	Tumors, cancer?
31	Yes	No	Heart infection?	43	Yes	No	Arthritis, rheumatism?
32	Yes	No	Heart surgery?	44	Yes	No	Eye diseases?
33	Yes	No	Heart murmurs?	45	Yes	No	Skin diseases?
34	Yes	No	Rheumatic fever?	46	Yes	No	Anemia?
35	Yes	No	Stroke, hardening of arteries?	47	Yes	No	VD (syphilis or gonorrhea)?
36	Yes	No	High blood pressure?	48	Yes	No	Herpes?
37	Yes	No	Asthma, TB, emphysema, other lung disease?	49	Yes	No	Kidney, bladder disease?
38	Yes	No	Hepatitis, other liver disease?	50	Yes	No	Thyroid, adrenal disease?
39	Yes	No	Diabetes?	51	Yes	No	Stomach problems, ulcers?
40	Yes	No	Family history of diabetes, heart problems, tumors?	52	Yes	No	Allergies to: drugs, foods, medications, latex?

IV. DO YOU HAVE OR HAVE YOU EVER HAD:

53	Yes	No	Psychiatric care?	58	Yes	No	Hospitalization?
54	Yes	No	Radiation treatments?	59	Yes	No	Blood transfusion?
55	Yes	No	Chemotherapy?	60	Yes	No	Surgeries?
56	Yes	No	Prosthetic heart vlave?	61	Yes	No	Pacemaker?
57	Yes	No	Artificial joint?	62	Yes	No	Contact lenses?

V. ARE YOU TAKING OR HAVE YOU TAKEN:

63	Yes	No	Any kind of medicine, drugs or pills?	66	Yes	No	Alcohol?
64	Yes	No	Phenfen?	67	Yes	No	Tobacco in any form?
65	Yes	No	Drugs, medication, pills, over-the-counter medicines	68	Yes	No	Bone supplements? Bisphosphonate, zometa, aredia?
			(including Coumadin, Aspirin, advil), blood thinners,	69	Yes	No	Diet pills
			natural remedies, herbal supplement, or homoeopathic?	70	Yes	No	Tranquilizers
			or homoeopathic remedy?				Please list any other medications you are taking:
			Please list: _____				_____

VI. ARE YOU ALLERGIC TO OR HAD A REACTION TO:

71	Yes	No	Local Anesthetics?	75	Yes	No	Asperin? Or Tylenol? Circle one
72	Yes	No	Penicillin?	76	Yes	No	Codeine or other narcotics?
73	Yes	No	Other antibiotics?	77	Yes	No	Other Medications?
74	Yes	No	Sodium penthothal, valium, or other tranquilizer?	78	Yes	No	Latex

Please list any other allergies other than drug allergies:

_____

_____

VII. Has your physician ever advised the use of premedication (antibiotics) before dental treatment?

79 Yes No If so, please explain: _____.

_____

_____

VIII. Do you have or have you had any other diseases or medical problems NOT listed on this form?

80 Yes No If so, please list: _____.

_____

_____

IX. FOR WOMEN ONLY:

81	Yes	No	Are you or could you be pregnant or nursing?	82	Yes	No	Taking birth control pills?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

PATIENT SIGNATURE: _____ **Date :** _____

The Health History is created and maintained by the University of the Pacific School of Dentistry, San Francisco, California.

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TMJ Screening History

Patient Name _____

1. Have you ever had a problem with jaw joints (your TMJs)? _____
2. Have you ever been injured by a blow to the jaw? _____
3. Do your jaw joints ever hurt or become tender when you chew or talk? _____
4. Do you notice any tenderness when you open wide? _____
5. Do you ever have any clicks, pops or grating sounds in your jaw joints?
6. Did you ever have any clicks or pops? _____
7. Do you have frequent headaches? Is so, how often? Where? _____
8. Has your jaw ever locked open? Closed? _____
9. Do you ever have difficulty opening? _____
10. Have you ever been treated for a TMJ problem? _____
    - Bite Splint
    - Medication
    - Surgery
    - Orthodontics
    - Physical Therapy
    - Equilibrium
    - Counseling

Doctor's Comment

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TREATMENT PLAN

Please check one:

- I prefer: _____ long-lasting solutions _____ temporary low-cost solution
- I prefer: _____ every detail of my care _____ just overall explanation
- I prefer: _____ the latest technically-advanced technique
  _____ tried and tested method
- I prefer: _____ to let my insurance coverage control my care
  _____ let my doctor control my care

Please answer with yes or no, and then explain:

- Do you like the appearance of your teeth? _____ your smile? _____

  _____

- Do you have spaces that you don't like? _____

  _____

- Do you like the color of your teeth? _____

  _____

- Do you like the shape of your teeth? _____

  _____

- Are there old fillings or dental work you don't like looking at? _____

  _____

- Are there any other concerns that you would like to address with Dr. Youngblood?

  _____

WOMEN NOTE: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.*

Is there any condition concerning your health that the doctor should be told? _____

Do you wish to speak to the doctor privately about anything? _____

Is there a family history of cancer? _____ Diabetes?_____ Heart disease? _____
Anesthetic problems? _____.

IN CASE OF EMERGENCY, CONTACT:
Name _____ Tel #: (___) _____. Bus # (___) _____.
Is the visit related to an accident? _____ Auto? _____ Work related? _____ Other? _____
Date of Injury _____ Ins Co. handling this claim _____
Claim #: _____
Name of attorney/adjustor _____ Tel #: (___) _____

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FEES AND PAYMENTS

We make every effort to keep down the cost of your dentist care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge**. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company**. You will be responsible for all collection costs, attorney's fees, and court costs.

X_____ _____
Signature of patient Date

This signature on file is my authorization for the release of information necessary to process my claim.
I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X_____ _____
Signature of patient Date

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for my errors or omissions that I have made in the completion of this form.

X_____ X _____ _____
Signature of patient Reviewed by Date

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ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

"You May Refuse To Sign This Acknowledgement"

I, _____ have received a copy of this office's

Notice of Privacy Practice.

_____
Please Print Name

_____
Signature

_____
Date

= : = : = : = : = : = : = : = : = : = : =

For Office Use Only

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

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgment**
- ☐ **Others (Please Specify)**

_____
_____
_____

This form is for educational only, does not constitute legal advice, and covers only Federal, Not State Law (August 14, 2002)

Notice of Privacy Practices

(Revised March 10, 2013)

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. If you have any questions about this Notice of Privacy Practices please contact our HIPAA Officer:

_____

This Notice of Privacy Practices describes how this facility may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that is maintained at that time. Upon your request, this facility will provide you with any revised Notice of Privacy Practices by calling the practice and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and disclosures of Protected Health Information are based upon your written consent. You will be asked by this facility to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and healthcare operations by signing the consent form. This facility will use or disclose your protected health information as described in this Section. Your protected health information may be used and disclosed by this facility, the office staff and others outside of our office that are involved in your care and treatment for the purpose of providing medical care services to you. Your protected health information may also be used and disclosed to pay your medical care bills and to support the operation of this facility practice.

2. Treatment: We will use and disclose your protected health information to provide, coordinate or manage your medical care and any related services. This includes the coordination or management of your medical care with a third party that has already obtained your permission to have access to your protected health information. In addition, this facility may disclose your protected health information to another physician or healthcare provider (e.g., a specialist or laboratory) who, at the request of this facility becomes involved in your care by providing assistance with your medical care diagnosis or treatment to this facility.

3. Payment: Your protected health information will be used, as needed, to obtain payment for your medical care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the medical care services this facility recommends for you

4. Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this facility's practice. In addition, this facility may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when the staff is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, this facility will have a written contract that contains terms that will protect the privacy of your protected health information.

5. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that this facility or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

6. Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then this facility may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your medical care will be disclosed.

7. Others Involved in Your Healthcare: Unless you object, this facility may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your medical care. If you are unable to agree or object to such a disclosure, this facility may disclose such information as necessary if it determines that it is in your best interest based on its professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person responsible for your care of your location, general condition or death.

8. Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, this facility will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If this facility is required by law to treat you and it has attempted to obtain your consent but is unable to obtain your consent, it may still use or disclose your protected health information to treat you.

9. Communication Barriers: We may use and disclose your protected health information if this facility attempts to obtain consent from you but is unable to do so due to substantial communication barriers and it determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

• Required By Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

• Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

• Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

• Health Oversight: This facility may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the medical care system, government benefit programs, other government regulatory programs and civil rights laws.

• Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, this facility may disclose your protected health information if it believes that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

• Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

• Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

• Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. This law enforcement purposes include:

• legal processes and otherwise required by law;
• limited information requests for identification and location purposes;
• pertaining to victims of a crime;
• suspicion that death has occurred as a result of criminal conduct;
• in the event that a crime occurs on the premises of the practice;
• medical emergency (not on this facility practice's premises) and it is likely that a crime occurred.
• Coroners: This facility may disclose protected health information to a coroner medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
• Criminal Activity: Consistent with the applicable federal and state laws, this facility may disclose your protected health information, if it believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. This facility may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
• Military Activity and National Security: When the appropriate conditions apply, this facility may use or disclose protected health information of individuals who are Armed Forces personnel:
• for activities deemed necessary by appropriate military command authorities;
• for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits;
• to foreign military authority if you are a member of that foreign military services. This facility may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
• Workers' Compensation: This facility may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.
• Required Uses and Disclosures: Under the law, this facility must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA Privacy Rule under§164.500 of the HIPAA Privacy Rule.

Your Rights

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

• You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as this facility maintains the protected health information. A "designated record set" contains medical and billing records and any other records that this facility uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records:
• information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding;
• protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our HIPAA Officer if you have questions about access to your medical record.

• You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. This facility is not required to agree to a restriction that you may request. If it believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If this facility does agree to the requested restriction, it may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with this facility. You may request a restriction by contacting our HIPAA Officer.

• You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our HIPAA Officer.
• You may have the right to request this facility to amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as this facility maintains this information. In certain cases, it may deny your request for an amendment. If this facility denies your request for amendment; you have the right to file a statement of disagreement with us and it may prepare a rebuttal to your statement and it will provide you with a copy of any such rebuttal. Please contact our HIPAA Officer to determine if you have questions about amending your medical record.
• You have the right to receive an accounting of certain disclosures this facility has made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures this facility may have made to you, to family members or friends involved in your care or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.
• *You have the right to the prohibition of the sale of your PHI;*
• *You have the right to opt-out of receiving fundraising communications;*
• *You have the right to be notified following a breach of unsecured PHI;*
• *You have the right to restrict disclosure of PHI to a health plan with respect to treatment for which the individual has paid fully out-of-pocket.*
• You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints

In the event you feel that there is cause for complaint we ask that you contact our office first and let us assist you in righting the matter.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. Please contact our HIPAA Officer, for further information about the complaint process.

This notice became effective on April 14, 2003.

Revised on March 10, 2013