WELCOME

PARKER K. WHITE, D.D.S.
Family Dentistry

Date: ______________________

Patient's Name: ______________________ Date of Birth: __________ Age: ______

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Name of Spouse: ______________________ Date of Birth: __________ Age: ______

If a Child, Parent's Name: ______________________

Street Address: ______________________ Phone: ______________________

City: ______________________ State: ______________ Zip: ________

Email: ______________________

Patient/Parent Employed By: ______________________ Phone: ______________________

Business Address: ______________________ Soc.Sec.# ______________________

Present Position: ______________________ Driver's License# ______________________

Spouse Employed By: ______________________

Business Address: ______________________ Spouse's Soc. Sec.# ______________

Present Position: ______________________ Spouse's D. L.# ______________

In Case of Emergency Call: ______________________ Phone: ______________________

Who Will Pay This Account:______________________

Do you have insurance that may cover any part of our professional services? ____________ Dual?__________

If so, Name of Company: ______________________ Group Policy# ______________

Dual Insurance Co. Name: ______________________ Group Policy# ______________

DENTAL HISTORY

Please mark "Yes" or "No" to indicate if you have or had any of the following:

Reason for today's visit: ______________________

____

Former Dentist: ______________________

City/State: ______________________

Date of last dental visit: ______________________

Date of last x-rays: ______________________

If you had a magic wand, what would you change about your teeth?______________________

____

____

____

Condition	Yes	No	Condition	Yes	No
Bad taste	Yes ☐	No☐	*Jaw pain or tiredness*	Yes ☐	No ☐
Bad breath	Yes ☐	No☐	*Lip or cheek biting*	Yes ☐	No ☐
Bleeding gums	Yes ☐	No☐	*Loose teeth or broken filling*	Yes ☐	No ☐
Blisters on lips or mouth	Yes ☐	No☐	*Mouth bleeding*	Yes ☐	No ☐
Burning sensation on tongue	Yes ☐	No☐	*Mouth pain, brushing*	Yes ☐	No ☐
Chew on one side of mouth	Yes ☐	No☐	*Orthodontic treatment*	Yes ☐	No ☐
Cigarette, pipe or cigar smoking	Yes ☐	No☐	*Periodontal treatment*	Yes ☐	No ☐
Clicking or popping jaw	Yes ☐	No☐	*Sensitivity to cold/head/sweets*	Yes ☐	No ☐
Dark teeth	Yes ☐	No☐	*Sensitivity when biting*	Yes ☐	No ☐
Dry mouth	Yes ☐	No☐	*Sores or growths in your mouth*	Yes ☐	No ☐
Fingernail biting	Yes ☐	No☐	*Unsightly teeth*	Yes ☐	No ☐
Food collection between teeth	Yes ☐	No☐	*How often do you floss? ______________*		
Grinding teeth	Yes ☐	No☐			
Gums swollen or tender	Yes ☐	No☐	*How often do you brush? ______________*		

MEDICAL HISTORY

Physician's Name: ______________________________ Date of last visit: ____________

Physician's Address: ____

Please mark "Yes" or "No" to indicate if you have or had any of the following:

AIDS	*Yes* ☐	*No* ☐	*Emphysema*	*Yes* ☐	*No* ☐	*Phen Fen Use*	*Yes* ☐	*No* ☐
Alcohol Use	*Yes* ☐	*No* ☐	*Epilepsy/Seizures or Convulsions*	*Yes* ☐	*No* ☐	*Prosthetic Replacement*	*Yes* ☐	*No* ☐
Anemia	*Yes* ☐	*No* ☐	*Fainting or Dizziness*	*Yes* ☐	*No* ☐	*Psychiatric Treatment*	*Yes* ☐	*No* ☐
Angina/Chest pain	*Yes* ☐	*No* ☐	*Fever Blisters/Mouth Ulcers or Canker Sores*	*Yes* ☐	*No* ☐	*Radiation Treatment*	*Yes* ☐	*No* ☐
Arthritis, Rheumatism	*Yes* ☐	*No* ☐	*Gout*	*Yes* ☐	*No* ☐	*Respiratory Disease*	*Yes* ☐	*No* ☐
Artificial Heart Valve	*Yes* ☐	*No* ☐	*Headaches*	*Yes* ☐	*No* ☐	*Rheumatic Fever*	*Yes* ☐	*No* ☐
Artificial Joint	*Yes* ☐	*No* ☐	*Hearing Problem*	*Yes* ☐	*No* ☐	*Scarlet Fever*	*Yes* ☐	*No* ☐
Asthma	*Yes* ☐	*No* ☐	*Heart Murmur*	*Yes* ☐	*No* ☐	*Shortness of Breath*	*Yes* ☐	*No* ☐
Back Problems	*Yes* ☐	*No* ☐	*Heart Problem*	*Yes* ☐	*No* ☐	*Sinus Trouble*	*Yes* ☐	*No* ☐
Bleeding abnormally	*Yes* ☐	*No* ☐	*Hemophilia*	*Yes* ☐	*No* ☐	*Skin Rash*	*Yes* ☐	*No* ☐
w/extractions or surgery	*Yes* ☐	*No* ☐	*Hepatitis Type*	*Yes* ☐	*No* ☐	*Stroke/TIA*	*Yes* ☐	*No* ☐
Blood Disease	*Yes* ☐	*No* ☐	*Herpes*	*Yes* ☐	*No* ☐	*Swelling of Feet or Ankles*	*Yes* ☐	*No* ☐
Blood Transfusion	*Yes* ☐	*No* ☐	*High Blood Pressure*	*Yes* ☐	*No* ☐	*Swollen Neck Glands*	*Yes* ☐	*No* ☐
Cancer	*Yes* ☐	*No* ☐	*HIV+*	*Yes* ☐	*No* ☐	*Thyroid Problem*	*Yes* ☐	*No* ☐
Chemical Dependency	*Yes* ☐	*No* ☐	*Jaundice*	*Yes* ☐	*No* ☐	*Tobacco Use*	*Yes* ☐	*No* ☐
Chemotherapy	*Yes* ☐	*No* ☐	*Jaw Pain*	*Yes* ☐	*No* ☐	*Tuberculosis*	*Yes* ☐	*No* ☐
Circulatory Problem	*Yes* ☐	*No* ☐	*Kidney Disease*	*Yes* ☐	*No* ☐	*Tumor/Growth on Head/Neck*	*Yes* ☐	*No* ☐
Cirrhosis	*Yes* ☐	*No* ☐	*Leukemia*	*Yes* ☐	*No* ☐	*Ulcer*	*Yes* ☐	*No* ☐
Congenital Heart Lesion	*Yes* ☐	*No* ☐	*Liver Disease*	*Yes* ☐	*No* ☐	*Venereal Disease*	*Yes* ☐	*No* ☐
Cortisone Treatments	*Yes* ☐	*No* ☐	*Low Blood Pressure*	*Yes* ☐	*No* ☐	*Vision Problem/Glaucoma or*	*Yes* ☐	*No* ☐
Cough, persistent or bloody	*Yes* ☐	*No* ☐	*Mitral Vale Prolapse*	*Yes* ☐	*No* ☐	*Cataract*	*Yes* ☐	*No* ☐
Diabetes	*Yes* ☐	*No* ☐	*Nervous Problem*	*Yes* ☐	*No* ☐	**Women:**		
Dialysis	*Yes* ☐	*No* ☐	*Pacemaker*	*Yes* ☐	*No* ☐	*Are you pregnant?*	*Yes* ☐	*No* ☐
Drug/ Alcohol rehabilitation	*Yes* ☐	*No* ☐				*Due date*		
Drug Use (illegal)	*Yes* ☐	*No* ☐				*Are you nursing?*	*Yes* ☐	*No* ☐

MEDICATIONS ALLERGIES

List medications you are currently taking________________

____

____

Pharmacy's Name: ___________________________

Pharmacy's Phone___________________________

ALLERGIES

(Causing swelling, rash, hives, itching or difficulty **breathing**)

- ☐ Aspirin
- ☐ Local Anesthetic
- ☐ Barbiturates (Sleeping pills)
- ☐ Penicillin or other antibiotics
- ☐ Codeine or other pain meds
- ☐ Sulfa
- ☐ Iodine
- ☐ Other Drugs:__________ ________________ ________________
- ☐ Latex

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT FIRST NAMED ABOVE, INCLUDING BUT NOT LIMITED TO WHATEVER DRUGS, MEDICINE, PERFORMANCE OF OPERATIONS, AND CONDUCT OF LABORATORY, X-RAY OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING DOCTOR OR QUALIFIED DESIGNATE. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY THEM IN FULL AT THE TIME OF SERVICE. I A CKNOWLEDGE THAT IT IS MY RESPONSIBILITY AND NOT AN INSURANCE COMPANY TO PAY FOR ANY OR ALL SERVICES. ANY OUTSTANDING BALANCE AFTER 30 DAYS MAY INCUR A FINANCE CHARGE OF 18% PER ANNUM OR 1-1/2% PER MONTH.

Signed:______________________________ ______________________ ______________

Patient, Parent or Guardian (Must be 18 years or older) Doctor Date

UPDATES

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

If so, what? ______________________

Are you taking any new medications? ☐ Yes ☐ No If so, what? ______________________

Patient's Signature ______________________________ Date ____________ _

Doctor's Signature ______________________________ Date ____________ _

Parker K. White, D.D.S., Inc.

563 Brunswick Road, Suite 3
Grass Valley, CA 95945
(530)272-9071

INFORMATION ABOUT OUR PRACTICE

Appointments:

We recognize how very valuable your time is; therefore, we schedule our dental appointments very carefully to assure all of our patients that they are seen promptly and that sufficient time is allotted for every procedure. Occasionally, a regularly scheduled patient may be required to wait in order for us to accommodate an emergency patient.

Cancellations and Broken Appointments:

If you find it is impossible to keep your appointment, please tell us ahead of time. In this way, we can reschedule your appointment and let another person have the time you could not make. For this reason, we ask for a 48 hour's cancellation notice. There will be a $50.00 charge for any appointments missed or cancelled at short notice.

Insurance Information:

We will be happy to process your insurance forms for you as long as you provide a current proof of coverage. We must have that information at the time of the appointment in order to bill your insurance; otherwise, you will be responsible for any charges incurred for the visit. Please be familiar with your insurance coverage and understand:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all insurance company contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. As healthcare providers, our relationship is with you, not your insurance company.
4. Any amount remaining once your insurance company has processed your claim; will be billed to you. Evan if you have paid your estimated co-pay.

Financial Policy:

Payment is to be received the day that the services are rendered. We accept cash, checks, Visa, MasterCard, and Discover. For those with insurance, your deductible and co-pay percentage are due at each visit. Payment plans are available for larger treatment plans with can be arranged with the office manager. Balances over 30 days will be assessed a 1% interest charge per month.

If you have any questions about the above information, please do not hesitate to as us. We are here to help you.

Signature:_______________________________________

Date :____

Parker K. White, D.D.S., Inc.

563 Brunswick Road, Suite 3
Grass Valley, CA 95945

Patient Acknowledgements and Authorization

I give permission to Dr. Parker White and the office staff to treat any of my oral and dental related problems. These include but are not limited to oral exam, professional cleaning, filling, extraction, crown and bridge, implant related work, etc. I understand that during the treatment it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during the examinations, the most common being root canal therapy following routine filling procedures. I give permission to the dentist to make any additional necessary changes.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the claim is submitted. Any treatment plan that our office proposes to you is an estimate of what your insurance coverage will be, it is not a guarantee. If you need exact payments and benefits, then a pretreatment estimate is required. If you would like this done, you must specify to the office before any work is initiated. (This takes 4-6 weeks).

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-pay is due in full the day of the treatment. If your insurance does not pay within 90 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan then pays, you will receive a refund check. Also remember dental insurance plans are not designed to cover all of your dental needs and plan coverage varies by each individual plan.

Signature: ____

Date:

Parker K. White DDS, Inc.

563 Brunswick Rd. Suite 3
Grass Valley, CA 95945

Notice of Privacy Practices
Patient Acknowledgement

Patient Name:___________________________________

Date of Birth:_____________________________________

I have read and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by the practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature:____

Date :____

Relationship to patient (if signed by guardian of patient):____

National 5ecurlty: 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 intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminder: 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 loot at or set 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 mate 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 $0.10 for each page, $20.CXI per hour for staff time to locate and copy your health Information, and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing you 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 listed 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 1n which we or our business associates disclosed your health Information for purposes, other than treatment. Payment healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting mom 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 cur use or disclosure of your health Information. We am not required to agree to these additional restrictions, but If we do, we will abide by cur agreement (except In an emergency).

Altemative Communication: You have the right to request that we communicate with you about your health Information by alternative means or to alternative Laotians. (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 mall (e-mail), you are entitled to receive this Notice In written form.

QUESTIONS AND COMPLAINTS

If you want more information about 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 using the contact Information listed 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 fife your complaint with 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 us or with the U.S. Department of Health and Human Services.

Contact Officer: parker.White.DDS

Telephone: 530-272- 9071

E-mail: drwhitedds@grassvalleydentlsrty.com

Address: 563 Brunswick Rd. #3 Grass Valley, CA 95945

Parker White, DDS

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. THE 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 right concerning your health Information. We must follow the privacy practices that are described in this Notice white it is in effect. This Notice takes effect October 16, 2019 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 the changes In our privacy practices and the new terms of our Notice effective for all health Information that we maintain, Inducting health Information we created or received before we made the changes. Before we make a significant change in 011r 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 the Notice, please contact us using the Information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclosure health Information about you for treatment, payment. and healthcare operation. For example:

Treatment: We may use or d1sdose your health information to a physician or other healthcare provider providing treatment to you.

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

Healthcare Operations: We may use and disclose your health Information In connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification 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 disclosure permitted by your authorization while it was 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. 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 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 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.