Arnold B Jacobs DDS 1400 Santa Rita Rd., G, Pleasanton,CA, 94566
925.846.3968

Please be assured that all of the information you provide will remain strictly confidential

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Patients full name:_____ Date:_____
Last *First* *MI* *Title*

Preferred name:_____ Sex: ◯ Male ◯ Female

Address:_____
Street *City* *State* *Zip Code*

SSN#:_____ DOB:_____

Home phone#:_____ Work#:_____ Cell#:_____

Email address:_____

Occupation:_____ Employer:_____

Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated ◯ Domestic Partner

In case of emergency, notify:_____ Relation:_____ Phone#:_____

Referred by:_____ Relation:_____

Insurance – Primary

For office use only *- Insurance card has been scanned:* ◯

Subscriber name:_____ Relationship to patient:_____ Subscriber DOB:_____

Subscriber SSN/ID#:_____ Subscriber employer:_____ Group#:_____

Insurance company name:_____ Insurance company phone#:_____

Insurance company address:_____
Street *City* *State* *Zip Code:*

Insurance – Secondary

Subscriber name:_____ Relationship to patient:_____ Subscriber DOB:_____

Subscriber SSN/ID#:_____ Subscriber employer:_____ Group#:_____

Insurance company name:_____ Insurance company phone#:_____

Insurance company address:_____
Street *City* *State* *Zip Code:*

Assignment and Release

Please read, initial and sign the following (if patient is a minor, parent or guardian must initial and sign)

_____ I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Arnold Jacobs DDS all insurance benefits, if any,
Initial otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize payment directly to the dentist named on the attached claim of the group insurance benefits otherwise payable to me. I authorize the use of this signature on all insurance submissions.

_____ I give my consent to use local anesthetic, general anesthetic, or relaxants for completing necessary dental treatment.
Initial

_____ I have received from the office of Arnold Jacobs DDS a copy of the **DENTAL MATERIALS FACT SHEET AND NOTICE OF PRIVACY PRACTICES.**
Initial

_____ I authorize Arnold B. Jacobs DDS to contact my physician in the form of a medical release, if necessary.
Initial

Patient (parent/guardian) signature:_____ Date:_____

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Medical History

Physician's name:_____ Physician's phone:_____

Date of last visit:_____ Your current physical health is: ◯ **Good** ◯ **Fair** ◯ **Poor**

Are you currently under the care of a physician? ◯ **Yes** ◯ **No** If yes, please explain:_____

Have you been hospitalized with a serious illness in the last three years? ◯ **Yes** ◯ **No** If yes, please explain:_____

_____

Do you use tobacco (smoke, chew, hookah, vape, etc.)? ◯ **Yes** ◯ **No** If yes, how much and how long?_____

Have you had a surgical implant (i.e. joint replacement) or artificial valve? ◯ **Yes** ◯ **No** If yes, please describe and include year of surgery:_____

_____

Please list any medications that you are on:_____

_____

Are you currently or have you ever taken bisphosphonates (including *denosumab, zolendronate, pamidronate, fosamox, boniva, actonel, prolia*)? ◯ **Yes** ◯ **No**

If yes, how much and for how long?_____

Do you take anticoagulants/blood thinners (*coumadin, eliquis, Plavix, daily aspirin,* etc.) ◯ **Yes** ◯ **No** yes, please list:_____

_____

Have you ever had excessive bleeding requiring special treatment? ◯ **Yes** ◯ **No** If yes, please explain:_____

_____

Have you ever had general anesthesia? ◯ **Yes** ◯ **No** If yes, please explain:_____

Have you ever had radiation treatment for cancer therapy? ◯ **Yes** ◯ **No** If yes, please explain:_____

Have you ever responded unfavorably to medical or dental care? ◯ **Yes** ◯ **No** If yes, please explain:_____

_____

Have you ever had an unfavorable reaction to nitrous oxide (laughing gas)? ◯ **Yes** ◯ **No** If yes, please explain:_____

Must you sleep with your head on more than one pillow? ◯ **Yes** ◯ **No** If yes, please explain:_____

Height:_____ Weight: _____

Have you ever had or experienced any of the following?

Yes	No	
◯	◯	Recent illness-past year
◯	◯	Heart or chest pain
◯	◯	Heart attack
◯	◯	Heart trouble
◯	◯	Heart murmur
◯	◯	Rheumatic fever
◯	◯	Mitral valve prolapse
◯	◯	Prosthetic heart valve
◯	◯	Pacemaker
◯	◯	Shortness of breath
◯	◯	High blood pressure
◯	◯	Low blood pressure
◯	◯	Organ transplant
◯	◯	Stroke
◯	◯	Parkinson's disease
◯	◯	Fainting
◯	◯	Lung disease
◯	◯	Asthma, emphysema, TB (circle)
◯	◯	Bronchitis
◯	◯	Cancer
◯	◯	Radiation treatment

Yes	No	
◯	◯	Facial radiation therapy
◯	◯	Chemotherapy
◯	◯	Diabetes I or II (circle)
◯	◯	Kidney disease
◯	◯	Liver disease
◯	◯	Hepatitis A B C D (circle)
◯	◯	Convulsions / epilepsy (circle)
◯	◯	Thyroid condition
◯	◯	Bleeding tendency
◯	◯	Anemia
◯	◯	Artificial joint
◯	◯	Venereal disease
◯	◯	Herpes
◯	◯	HIV / AIDS (circle)
◯	◯	Family history of diabetes, heart disease (circle)
◯	◯	Eye disease
◯	◯	Contact lenses
◯	◯	Skin disease
◯	◯	Psychiatric care
◯	◯	Blood transfusions
◯	◯	Cortisone, ACTH, Prednisone (circle)

Yes	No	
◯	◯	Recreational Drugs
◯	◯	Substance Abuse
◯	◯	Medical Marijuana

Any allergies/unusual reactions to:

Yes	No	
◯	◯	Penicillin
◯	◯	Sulfa
◯	◯	Codeine
◯	◯	Aspirin
◯	◯	Latex
◯	◯	Iodine
◯	◯	Dental anesthetics
◯	◯	Metals
◯	◯	Erythromycin
◯	◯	Other:_____

If female, please answer:

Yes	No	
◯	◯	Are you taking birth control pills?
◯	◯	Are you pregnant?
		If so, # weeks:_____
◯	◯	Are you nursing?

Do you have or have you had any other disease or medical condition **NOT** listed on this form? ◯ **Yes** ◯ **No**

If so, please explain:_____

To the best of my knowledge, I have answered all subsequent questions completely and accurately. I will inform my dentist of any change in my health and/or medications.

Patient (parent/guardian) signature:_____ Date:_____

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We are always striving to improve communication and prioritize convenience for our patients. We would like to communicate with you via email and text messaging for ADMINISTRTIVE PURPOSES. Examples of this type of information are listed below:

Confirming and notifying you regarding yours or your child's appointments.

Your estimate of your recommended treatment and patient financial obligations.

It is important to note that this type of communication is not always secure. Emails and text messages can be intercepted. For this reason**, WE DO NOT COMMUNICATE PERSONAL CONFIDENTIAL INFORMATION VIA EMAIL OR TEXT MESSAGING.**

◯ **I DO** consent and accept the risk in receiving information via email. I understand that I can withdraw my consent at any time.

◯ **I DO** consent only to receiving appointment reminders via ◯ **email** or ◯ **text**. I understand that I can withdraw my consent at any time.

◯ **I DO NOT** consent to receiving any information via email.

Please fill out the information below and sign up for email and text messaging communication from our office (information about appointments and financial estimates only):

For patients 18 years and older:
Your name: _____
Your email: _____
Your cellphone#: _____
Your cellphone carrier: _____

For patients 17 years and younger:
Your name: _____
Your email: _____
Your cellphone#: _____
Your cellphone carrier: _____

Patient/Representative Name: _____

Patient/Representative Signature: _____ Date: _____

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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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 8/16/2010, 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, 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 provide the new Notice at our practice location, and we will distribute it 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 listed at the end of this Notice.

Your Authorization: In addition to our use of your health information for the following purposes, 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 disclosures 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes:

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose 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 provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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, certification, licensing or credentialing activities.

To You or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an 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 you 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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost -based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.25 for each page, $25 per hour for staff time to 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 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 in 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 more 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 our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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 file 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: Arnold B. Jacobs DDS

Telephone: 925.846.3968

E-mail: arnoldjacobsstaff@att.net
Address: 1400 Santa Rita Rd., G Pleasanton, CA, 94566