Joanne Suarez Martinez, D.D.S.

26711 Aliso Creek Rd. Suite 200C
Aliso Viejo, CA 92656
Ph. 949-349-0303 Fax 949-349-0664

PATIENT HISTORY RECORD

Child's Name _____ Nickname _____

Age _____ Date of Birth _____

Reason for your visit _____

Who may we thank for referring you? _____

MEDICAL HISTORY

Child's physician _____ City _____ Phone: ( ) _____

Date last saw physician: Month _____ Year _____

1. Is your child presently under the care of a physician for any medical problem or condition? ❑ Yes ❑ No
   Please explain _____
2. Is your child currently taking any medication? ❑ Yes ❑ No
   What? _____ Dosage _____

Has your child had / experienced any of the following? (please circle)

Abnormal Bleeding	Y	N	Congenital Birth Defect	Y	N	Heart Murmur	Y	N	Recurrent Headaches	Y	N
AIDS / HIV+	Y	N	Congenital Heart Defect	Y	N	Hemophelia	Y	N	Rheumatic Fever	Y	N
Allergies	Y	N	Diabetes	Y	N	Hepatitis	Y	N	Seizures	Y	N
Anemia	Y	N	Endocrine System Disorders	Y	N	High Blood Pressure	Y	N	Scarlet Fever	Y	N
Any Hospital Stays	Y	N	Epilepsy	Y	N	Hives	Y	N	Sickle Cell Anemia	Y	N
Any Operations	Y	N	Frequent Infections	Y	N	Kidney Problems	Y	N	Sight Disorders	Y	N
Asthma	Y	N	Handicaps	Y	N	Liver / GI System Problems	Y	N	Significant Injuries / What	Y	N
Blood Dyscrasis	Y	N	ADD/ADHD	Y	N	Low Blood Pressure	Y	N	Skin Rash	Y	N
Blood Transfusion / Date	Y	N	Autism	Y	N	Lupus	Y	N	Tonsilitis	Y	N
Breathing / Lung Problems	Y	N	Behavior / Learning Disabilities	Y	N	Measles	Y	N	Tuberculosis (TB)	Y	N
Cancer / Tumors	Y	N	Mentally / Physically Disabled	Y	N	Mitral Valve Problems	Y	N			
Chicken Pox	Y	N	Hearing Impaired	Y	N	Mononucleosis	Y	N			

DENTAL HISTORY

I. Is this your child's first dental visit? ❑ Yes ❑ No
   Previous dentist _____ City _____ Date of last visit _____
2. Has your child had an unfavorable experience in a previous dental (or medical) office? ❑ Yes ❑ No
3. Have there been any injuries to your child's teeth or jaws , falls, blows, chips, etc.? ❑ Yes ❑ No
4. Does your child receive fluoride vitamins, tablets, water, etc.? ❑ Yes ❑ No
5. Has your child been seen by an orthodontist? ❑ Yes ❑ No
6. Name of Parent's dentist _____ City _____ Phone: ( ) _____
7. Is your child currently in pain? ❑ Yes ❑ No

Does / did your child have any of the following habits? (please circle)

Lip Sucking and Nail Biting	Y	N	Clenching / Grinding Teeth	Y	N	Tongue / Cheek Biting	Y	N	Mouth Breather	Y	N
Chewing on Objects	Y	N	Thumb / Finger Sucking	Y	N	Used Pacifier	Y	N	Speech Problems	Y	N
TMJ / TMD Pain	Y	N	Nursing Bottle Habits	Y	N	Tongue Thrust	Y	N	Breast Fed	Y	N

FAMILY RECORD

Residence Address _____ City _____ Zip _____

Home Phone _____

Father's full name _____ Cell Phone _____

Address if different _____ City _____ Zip _____

Employer _____ Work Phone _____

Work Address _____ City _____ Zip _____

Email _____ S.S.# _____ Birthdate _____

Mother's full name _____ Cell Phone _____

Address if different _____ City _____ Zip _____

Employer _____ Work Phone _____

Work Address _____ City _____ Zip _____

Email _____ S.S.# _____ Birthdate _____

FAMILY RECORD (cont)

Please list the names of all brothers and sisters and their ages: _____

_____

Has any member of your family been a patient in this office before? ..... ❑ Yes ❑ No

If yes, name_____

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

1. Is your child covered by a dental insurance plan? ..... ❑ Yes ❑ No

Primary Plan

Insurance Co. Name _____ Phone: ( )_____ Group No. or Policy No._____

Insurance Co. Address _____ City _____ State _____

Name of insured_____ Social Security No. _____

Employer of insured_____ Birthdate of insured _____

Secondary Plan

Insurance Co. Name _____ Phone: ( )_____ Group No. or Policy No._____

Insurance Co. Address _____ City _____ State _____

Name of insured_____ Social Security No. _____

Employer of insured_____ Birthdate of insured _____

I HEREBY AUTHORIZE DR. JOANNE SUAREZ/MARTINEZ AND/OR THEIR ASSOCIATES TO PERFORM ANY AND ALL TREATMENT FOR MY ABOVE-NAMED CHILD AND CONSENT TO SUCH METHODS, DRUGS AND AGENTS AS MAY BE INDICATED IN CONNECTION WITH HIS/HER DENTAL CARE. THIS CONSENT SHALL REMAIN IN EFFECT UNTIL CANCELLED.

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependants.

Signature _____ Date _____

To the best of my knowledge, the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and I or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operation.

Signature _____ Date _____

Medical history review:

___/___|___/___|___/___|___/___|___/___|___/___|___/___|___/___|___/___|___/___|___/___|___/___|___/___

Joanne Suarez Martinez, D.D.S.
26711 Aliso Creek Rd. Suite 200C
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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 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, 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 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 listed 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 providing treatment to you.

Payment:

We may use and disclose your health information to obtain payment for services we provide 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 qualifications 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 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.

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.

(over please)

National Security:
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 official 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 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. 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 $10.00 for each page, 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 listed at the end of this Notice fora 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, paymnent, 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. 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 or 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.

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: Andrea Hopper

Telephone: 949-349-0303

Joanne Suarez Martinez, D.D.S.

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Consent for Treatment

1. The undersigned hereby authorizes Dr. Joanne Suarez Martinez and Associates to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Joanne Suarez Martinez and Associates to make a thorough diagnosis of my child's dental needs. I also authorize Dr. Joanne Suarez Martinez and Associates to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication and therapy indicated for such treatment.
2. I certify that my child is covered by Insurance Co. and I assign directly to Dr. Joanne Suarez Martinez all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.
3. To avoid a missed appointment charge of $50, we request that you cancel at least 24 hours prior to your child's scheduled appointment. We greatly appreciate your cooperation.
4. A $25 fee is automatically charged to your account for all returned checks.
5. I understand it is my responsibility to advise your office of any changes in the information contained on these forms.

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I acknowledge I have received a copy of the Dental Materials Fact Sheet.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Joanne Suarez Martinez, D.D.S.
26711 Aliso Creek Road. Suite 200C
Aliso Viejo, CA 92656
Ph: 949-349-0303
Fax: 949-349-0664

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunities to read and consider the contents of this Consent Form and notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify)

Child's Name:
Parent/Guardian:
Relationship:
Date:
Signature: