Medical Questionnaire

Last Name_______________________________________ First Name ________________________________

Address ___________________________________ City _______________ State _____ Zip Code ___________

Home Phone ___________________ Work Phone ____________________ Cell Phone ____________________

Birth Date ______/ _______/ _______ Gender: M F Height _______ Weight ________ Marital Status: S M D W

Social Security Number _________- _______ - ________ E-mail __________________________________

Employer ______________________________________ Profession _________________________________

Emergency Contact ____________________________________ Phone ________________________________

For the following questions, please circle which answer applies. If you do not know the answer, circle the "?". Your answers are for our records only and will be kept confidential in accordance with the applicable laws. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental information

Yes No ? Do your gums bleed when you brush?

Yes No ? Are your teeth sensitive to hot, cold, sweets, or pressure?

Yes No ? Have you had any periodontal (gum) treatments?

Yes No ? Have you ever had orthodontic (braces) treatment?

Yes No ? Do you wear removable dental appliances?

Yes No ? Have you had a serious/difficult problem associated with any previous dental treatment? If so explain ____

____

How would you describe your current dental condition? ____

Date of your last dental exam ______________________ Date of your last x-rays _________________________

Was any treatment done at that time? If so, what treatment? ______________________________________

Are you happy with the appearance of your teeth? ____

Medical Information

Yes No ? Are you in good health?

Yes No ? Has there been any change in your general health with the past year?

Name of physician ____

City ______________________________ Phone number _________________________________

Yes No ? Are you currently under the care of a physician for a specific condition?

If so, what condition(s) ____

Yes No ? Have you had any serious illness, operation, or been hospitalized in the past five years? If so, explain _________

____

Yes No ? Are you taking or have recently taken any medicine(s), including non- prescription medicine? If so, what medicine(s) are you taking? Prescribed ________________________________ Over the counter ______

______________________________ Natural or herbal preparation_____________________________

Yes No ? Are you taking or have taken any diet drugs such as Pondimin (fendluramine) Redux(dexphenfluarmine) or Phen-fen (phentermine)?

Yes No ? Are you taking or have taken any biphosphonate drugs such as Fosamax, Boniva or Actonel to treat osteoporosis or other bone-related disease?

Yes No ? Do you wear contact lenses?
Yes No ? Have you had an Orthopedic total joint (hip, knee, elbow, finger) replacement?
If so, when was the operation done?____
Yes No ? Have you had any complications or difficulties with your prosthetic joint?
Yes No ? Has a physician or a previous dentist ever recommended that you take antibiotics prior to your dental treatment?

Allergies: Are you Allergic to or have you had an allergic reaction to any of the following:____________________

Yes No ? Local anesthetics
Yes No ? Penicillin or other antibiotics
Yes No ? Aspirin
Yes No ? Codeine or other antibiotics
Yes No ? Barbiturates, sedatives, sleeping pills
Yes No ? Sulfa Drugs
Yes No ? Latex
Yes No ? Iodine
Yes No ? Pollen
Yes No ? Animals
Yes No ? Foods __________________________________
Yes No ? Other__________________________________

For female patients:____

Yes No ? Are you pregnant?
Yes No ? Are you nursing?
Yes No ? Are you taking birth control pills?

Please circle if you have or had any of the following. If you do not know the answer, circle the "?":__________________

Yes No ? Abnormal Bleeding
Yes No ? HIV or AIDS
Yes No ? Anemia
Yes No ? G.E. reflux
Yes No ? Hepatitis, jaundice
Yes No ? Diabetes- If so, Type I or Type II
Yes No ? Osteoporosis
Yes No ? Headaches, migraines
Yes No ? Neurological disorders
Yes No ? Stroke
Yes No ? Mental health disorders
Yes No ? Blood transfusion
If so, when: ____________
Yes No ? Cancer/ chemotherapy/ radiation
If so, when: ____________
Yes No ? Dry Mouth
Yes No ? Arthritis
Yes No ? Asthma
Yes No ? Glaucoma
Yes No ? Hemophilia
Yes No ? Low blood pressure
Yes No ? STD
Yes No ? Tuberculosis
Yes No ? Sinus problems
Yes No ? Ulcer
Yes No ? Sleep Disorder
Yes No ? Cardiovascular diseases:
-Angina
-Arteriosclerosis
-Mitral valve prolapse
-Coronary occlusion
-Heart murmur
-Pacemaker
-High blood pressure
-Artificial heart valves
-Damaged heart valves
-Heart attack
-Congenital heart defects
-Rheumatic heart disease

Yes No ? Eating disorder- if so, specify ____
Yes No ? Recurrent infections- if so, specify ____
Yes No ? Severe or rapid weight loss
Yes No ? Epilepsy
Yes No ? Fainting spells or seizures
Yes No ? Sores or ulcers in the mouth
Yes No ? Persistent swollen glands in neck
Yes No ? Do you have any disease, condition, or problem not listed here that you think we should know about?
____

I certify that I have read and that I understand the above. I will not hold my dentist, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form.

Signature of patient or legal guardian: ____ **Date** ________________

Patient Name:____

Who may we thank for referring you?____

We at Dr. Boisvert's office are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental care available today. In addition, we are also dedicated to making top-quality care as cost-effective as possible.

Payment for dental services is expected at the time the service is rendered. We do not bill for dental treatment. To assist you with your healthcare investment, we provide the following payment options:

Cash–includes money orders and personal checks
MasterCard/Visa/American Express/Discover
Care Credit– an outside financing plan which is a line of credit to cover you and your family members' healthcare needs.

Dental Insurance:

If you are covered by a dental insurance plan, please make sure you provide your insurance information to our office staff. As a courtesy to our patients, we will bill your insurance for you. 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. We will accept assignment of benefit for most plans. You will be expected to pay your estimated co-pay at the time of service. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to know your benefits, pay any deductible amount, co-insurance or any other balance not paid by your insurance. We will contact your insurance carrier prior to your visit to get a current benefit summary. We will advise you of your benefits as told to us by the insurance carrier. All benefits that are quoted to us are only valid as long as your employment status and company contract do not change during your treatment. It is your responsibility to advise us of any changes in regards to your insurance coverage.

There are a few dental insurances that reimburse the patient directly, such as Delta Dental and some Anthem Blue Cross/ Blue Shield plans. If you are covered by any of these companies, we will still bill your treatment for you, but ask that you pay for your treatment at the time of service.

I hereby assign dental benefits to: Lorène A. Boisvert, D.D.S.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance (if applicable). I hear by authorize the said assignee to release all information necessary to secure payment for dental services provided. This includes disclosure of portions of my dental records when applicable.

In the event that full payment for charges incurred for my dental care are not made, I agree to pay all costs for collection including reasonable attorney's fees and interest at the rate of eighteen percent (18%) per annum.

Missed Appointment / Cancellation Policy:

At Biosmile Dentistry we are committed to providing all of our patients with exceptional care. When a patient cancels without giving us enough notice, it prevents another patient from being seen. Please email us at hello@biosmiledentistry.com or call us at (310) 310-4696 **48 hours prior to your scheduled appointment** to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. **If prior notification is not given, you will be charged $125 per hour for the missed appointment.** If a patient is more than 15 minutes late, **an additional fee of $25 per hour will be charged for the late appointment.**

Signed: ____ Date:________________________

2428 Santa Monica Blvd Suite 303, Santa Monica, CA 90404 ...(310) 310-4696 ...hello@biosmiledentistry.com

Notice of Privacy Practices

This notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect April **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 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. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment and health care operations. For example:

Treatment: We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care 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 health care 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 is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

Unsecured Email: We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 your 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 health care. 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 may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Fkdqjh#ri#Rzqhuvkls=#If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.#

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

Public Health: We may and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Notice of Privacy Practices (continued)

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 to authorized federal official's 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 inmates or patients under certain circumstances.

Appointment Reminders: We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement: Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

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 contacting our office. 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. If you request copies, we will charge you **$0.75** for each page **$20.00** per hour 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 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 for a full explanation of our fee structure.

Disclosure Accounting: You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.
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 of how payments will be handled under the alternative means or location you request.

Breach Notification: In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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 Website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

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 also 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 against you for filing a complaint with us or with the U.S. Department of Health and Human Services.

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: **Morgan Williams, Front Office Coordinator**
Telephone: **(310) 310-4696** **Fax: (310) 575 2982**

Email: **hello@biosmiledentistry.com**
Address: **2428 Santa Monica Blvd Suite 303 Santa Monica, CA 90404**

Dr. Lorene Boisvert complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, or disability

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

{Please Print Patient's Name}

{Signature}

{Date}

For Office Use Only

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

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

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Smile Assessment Questionnaire

Are you pleased with the general appearance of your teeth and smile?

- ☐ Yes
- ☐ No

If no, what would you like to be different?

Are your teeth straight?

- ☐ Yes
- ☐ No

Have you ever had orthodontic treatment?

- ☐ Yes
- ☐ No

Are you satisfied with the color of your teeth?

- ☐ Yes
- ☐ No

Are you satisfied with the shape of your teeth?

- ☐ Yes
- ☐ No

Are there any spaces between your teeth that you dislike?

- ☐ Yes
- ☐ No

Are you satisfied with the way your teeth come together (your bite)?

- ☐ Yes
- ☐ No

Do you have old fillings or dental work that makes you feel less confident about your smile or appearance?

- ☐ Yes
- ☐ No

What would you like to change about the appearance of your smile?