

Dr. Glenn Giamo  
935 Trancas St. Suite 5B  
Napa, California 94558

## PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ <sup>FIRST</sup> \_\_\_\_\_ <sup>MI</sup> \_\_\_\_\_ <sup>LAST</sup> \_\_\_\_\_ Cell # \_\_\_\_\_  
SS# \_\_\_\_\_  Male  Female Birthdate \_\_\_\_\_ Home phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Check appropriate box:  Minor  Single  Married  Divorced  Widowed  Separated  
Patient's or parent's employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Business address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or parent's name \_\_\_\_\_ Employer \_\_\_\_\_ Work phone \_\_\_\_\_  
If patient is a student, name of school/college \_\_\_\_\_  
 Part time  Full time City \_\_\_\_\_ State \_\_\_\_\_ email: \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Relative to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

### Responsible Party

Name of person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_ Home phone \_\_\_\_\_  
Driver's license # \_\_\_\_\_ Birthday \_\_\_\_\_ Financial institution \_\_\_\_\_  
Employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Is this person currently a patient at our office?  Yes  No

### Insurance Information

Name of person carrying insurance \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthday \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date employed \_\_\_\_\_  
Name of employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Address of employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ Union or local # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you have any additional insurance?  Yes  No If yes, complete the following:

Name of other person carrying insurance \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Birthday \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date employed \_\_\_\_\_  
Name of employer \_\_\_\_\_ Work phone \_\_\_\_\_  
Address of employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance company \_\_\_\_\_ Group # \_\_\_\_\_ Union or local # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. PLEASE REMEMBER INSURANCE BENEFITS ARE A CONTRACT BETWEEN THE PATIENT AND SAID INSURANCE COMPANY, NOT THE DENTIST AND SAID INSURANCE COMPANY. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED. THANK YOU.

X \_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

# Patient Medical History

Physician \_\_\_\_\_ OfficePhone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you under medical treatment now? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	8. Are you allergic to or have you had any reactions to the following?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain) .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other Antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you taking any blood thinner medications? .....	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use controlled substances? .....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you wearing contact lenses? .....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have or have you had any of the following?			Iodine .....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc) .....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber .....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles .....	<input type="checkbox"/>	<input type="checkbox"/>	Other (please list) _____	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	9. Women Only:		
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions .....	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives? .....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases .....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Diseases .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss .....	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Replacement or Implant .....	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis / Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually Transmitted Disease .....	<input type="checkbox"/>	<input type="checkbox"/>			
Stomach Troubles / Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>			

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Do your gums bleed while brushing or flossing? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	8. Do you have frequent headaches? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are your teeth sensitive to hot or cold liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking? .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face)? .....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing? .....	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing? .....	<input type="checkbox"/>	<input type="checkbox"/>			

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X  
 Signature of patient (or parent if minor) \_\_\_\_\_ Print Name \_\_\_\_\_

Doctor's Comments _____
Signature _____ Date _____

## NOTICE OF PRIVACY PRACTICES

### Protecting Your Confidential Health Information is Important to Us

#### 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.

#### Our Promise

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA—Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

#### Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

## NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

#### As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

#### Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

#### Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

#### For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

#### How Your HEALTH INFORMATION May be Used to Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

#### To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

#### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

#### In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

#### To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

#### Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

#### Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

#### Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

#### Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

#### Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

#### To Avert a Serious Threat to Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Dr. Glenn Giamo  
(707) 252-3600

# Protecting Your Confidential Health Information is Important to Us

## To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

### For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

### In Connection With Your Death or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

### Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

## PATIENT RIGHTS

You have the following rights related to your health information.

### Restrictions

You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

## Patient Acknowledgment

Patient Name(s): \_\_\_\_\_

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

\_\_\_\_\_  
Patient Signature

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

## Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

## Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

## Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

## Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

## Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

## Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

## Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

## Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013