PermaDontics center
RESTORING LIVES WITH PERMANENT SMILE SOLUTIONS
8008 Frost St. Suite 300, San Diego, Ca 92123
Office Number: (858)292-5050

DIRECTIONS TO OUR OFFICE:

PermaDontics is located at 8008 Frost Street in San Diego off the 163 freeway by Sharp Memorial and Children's Hospital:

Which freeway is closest to you? The 5 or the 15?

5 Freeway: Are you closer to the 52 or the 8?

52: Head east to the 805 SOUTH to the 163 (one-sixty-three) SOUTH and get off at Genesee – make a left. You will turn left again at Health Center Drive. Take the 2nd right onto Frost Street and we're located on the LEFT hand side at 8008 Frost street.

8: Head east to the 163 (one-sixty-three) NORTH and get off at Mesa College Drive toward Kearny Villa Road – make a right. You will turn right again at Berger Ave. Take the 1st right onto Frost Street and we're located on the RIGHT hand side at 8008 Frost street.

15 Freeway: Are you closer to the 163 or the 8?

163: Take the 163 (one-sixty-three) SOUTH and get off at Genesee – make a left. You will turn left again at Health Center Drive. Take the 2nd right onto Frost Street and we're located on the LEFT hand side at 8008 Frost street.

8: Head west to the 805 NORTH and get off at Mesa College Drive/Kearny Villa Rd – make a left. You will turn left again on Health Center Drive. Turn left onto Frost Street and we're located on the left hand side at 8008 Frost Street Suite 300.

Notice of Privacy Practices

To our patients. **This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: *PermaDontics 8008 Frost St. Ste. 300, San Diego, CA 92123 or Fax to: 858-292-5468.*

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: *PermaDontics 8008 Frost St. Ste. 300, San Diego, CA 92123 or Fax to: 858-292-5468.* You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Practice Manager at *PermaDontics 8008 Frost St. Ste. 300, San Diego, CA 92123*. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If a disclosure of your protected health Information was made for a reason other than treatment, payment, or health operations, you have a right to receive an accounting of the disclosure.

If you have any questions regarding this notice or our health information privacy policies, please contact the Practice Manager. I hereby acknowledge that I have been presented with a copy of PermaDontics Notice of Privacy Practices, Pages 1, & 2.

PLEASE PRINT AND COMPLETE ALL INFORMATION ON THIS FORM

Patient Information

Name: _____

Date: _____

Mr/Ms/Mrs First Name Last Name MI

Sex: ☐M ☐F Birthdate: _____ Age:_____ Marital Status: ☐S ☐M ☐D ☐W

Home Phone: _____ Cell Phone: _____

Address: _____ City _____

State_____ Zip_____ Email Address: _____

Employer:_____ Occupation: _____ Phone:_____

Emergency Contacts Name:_____Relation: _____Phone: _____

How did you hear about us? Please be specific and fill in the blank :

Radio:_____ Newspaper:_____ Website: _____ TV: _____ Referral: _____ Other: _____

Dental History

Reason for Today's Visit/ If you could improve your current dental condition what would you change?

_____

_____

Do you have a fear of the dentist? ☐Yes ☐No Are you in pain? ☐Yes ☐No Location?_____

Are you wearing a denture? ☐Yes ☐No Or a partial? ☐Yes ☐No How Long? _____

Current Dentist:_____ Phone:_____ Last Exam Date: _____

Please check (√) if you have had problems with any of the following:

☐ Bad Breath ☐ Grinding Teeth ☐ Loose Teeth ☐ Clicking or Popping of Jaw ☐ Bleeding Gums

Health History

Are you in good health? ☐Yes ☐No Height: _____ Weight: _____

Medical Doctor: _____ Phone:_____

Cardiologist: _____ Phone:_____

Any ongoing medical problems/ Recent Hospitilizations or illnesses / Are you under the care of a physician?

_____

_____

Do you have any unhealed/recurrent injuries or inflamed areas/growths or sore spots in or around your mouth? ☐Yes ☐No

If so where? _____ Do you have any prosthetic joints/implants? ☐Yes ☐No Where? _____

Have you ever had heart surgery? ☐Yes ☐No When?_____ What kind? _____

To our patients: Although oral surgeons treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medication that you may be taking could have an important inter-relationship with the care that you will be receiving. Thank you for answering the questions above. Your answers are for our record and will be considered confidential.

ALLERGIES- Are you allergic to, or had a reaction to…					
----------	Yes	No	----------	Yes	No
Local anesthetic?			Valium, or other tranquilizers?		
Penicillin?			Aspirin?		
Other Antibiotics?			Codeine or other narcotics?		
Sulfa Drugs?			Latex?		
Sodium Pentothal?			Soy?		
Sulfites?			Eggs/yolk?		
Please List any other allergies:					

MEDICATIONS- Are you now taking…			Notes
----------	Yes	No	
Blood Thinners?			
Herbal supplement or homeopathic remedy?			
Any bone density medication?			
Have you ever taken tranquilizers, sleeping pills, anti depressants, and/or narcotics on a regular basis? If so please list:			
Please list any medication you are currently taking:			

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Do you have a family history of: □Cancer □Diabetes □Heart Disease □Anesthetic Problem □None

Do you wish to speak to the doctor privately about anything? □Yes □No

Have you had or do you currently have any of the following please (√) in the box:

□ Mitral Valve
□ High Blood Pressure
□ Low Blood Pressure
□ Chest Pain/Angina
□ Heart Attacks /When:_____
□ Irregular Heart Beat
□ Cardiac Pacemaker
□ Heart Surgery
□ Bronchitis
□ Chronic Cough
□ Asthma
□ Sinus Problem
□ Snoring
□ Sleep Apnea
□ Difficult Breathing/Lung Problems
□ Emphysema
□ Smoke Cigarettes / How Much: _____
□ Contagious Disease/Which Type: _____

□ Malignant Hyperthermia
□ Delayed Healing
□ Infectious Mononucleosis
□ Liver Disease
□ Jaundice/When: _____
□ Hepatitis/Which Type: _____
□ STD/What Type_____
□ Bleeding Tendency
□ Bruise Easily
□ Blood Disorder
□ Convulsions/Epilepsy
□ Thyroid Problem
□ Diabetes/Which Type: _____
□ Kidney Problem
□ Dialysis
□ Cancer/ Which Type: _____
□ Osteoporosis/Osteopenia
□ Stomach Ulcers

□ Fainting Spells
□ Contact Lenses
□Tumor/Growth
□ Chemotherapy
□ Arthritis
□ Chronic Fatigue
□ Currently Dieting
□ Drug Abuse
□ Alcohol Abuse
□ Eye Disease
□ Mental Health Problem
□ Stroke
□ Removable Appliance
□ Dental Splint
□ Pregnant or Nursing
□ Immune- Suppressed
□ Chew Tobacco
□ Rheumatic Fever

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omission that I have made in the completion of this form.

Signature: _____ **Date**: _____

PermaDontics is a specialized Dental Implant Center. We do not contract with any insurance companies. In this way we keep our cost down enabling us to pass along these savings to you and can better provide exceptional value without insurance delays.

I authorize my surgeon and his/her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, by signing this document you understand and agree to the above policy.

Signature: _____ **Date**: _____

3D CT scans are complimentary for diagnostic and treatment purposes for our in house patients. There is a fee for replication of your scan onto a disc and/or print out, should you request for personal use**.**

Please Initial: _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature: _____ **Date**: _____