HONDA PLAZA DENTAL CLINIC

400 E. 2nd Street, #207 Los Angeles, CA 90012 Ph. 213.687.3895

REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: Mr. □ Miss □ Mrs. □ Ms. □ Other □

Marital status (Check one)
□ Single/□ Mar/ □ Div/ □ Sep / □ Wid

Is this your legal name? □ Yes □ No

If not, what is your legal name?

Social Security #:

Birth date:

Age:

Sex: □ M □ F

What is your preference of communication? Email □ Phone □ Text □

Home Phone number:

Cell Phone number:

Street address:

City:

State:

Zip Code:

Occupation:

Employer:

Employer phone no:

Referred to clinic by (Please check one box):
□ Dr. □ Friend
□ Insurance Plan □ Hospital □ Family □ Close to home/ work □ Other

Email:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary Dental Insurance:

Group no: Policy no: Insurance phone no:

Subscriber's name: Subscriber's SSN: Subscriber's Birth date:

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other

Please indicate secondary Dental Insurance:

Group no: Policy no: Insurance phone no:

Subscriber's name: Subscriber's SSN: Subscriber's Birth date:

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other

IN CASE OF EMERGENCY

Name of local friend or relative Relationship to patient: Phone no:

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MEDICAL HISTORY

Are you in good health? (健康ですか?) □ Yes □ No Do you smoke or use tobacco? (タバコを吸いますか?) □ Yes □ No

Are you currently being seen or treated by a physician? (現在、お医者様に掛かっていますか?) □ Yes □ No

Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done?

(医師または以前の歯科医に、歯科治療前に抗生物質を取るように薦められていますか?) □ Yes □ No

(Please check)

Y	N	Conditions:	Y	N	Conditions:	Y	N	Conditions:
□	□	Pacemaker (ペースメーカー)	□	□	Cancer (癌) Type:	□	□	G.E. reflux (GERD) (胃食道逆流症)
□	□	Artificial heart valve (人工心臓弁)			Date of diagnosis:	□	□	Gastrointestinal disease (胃腸の病気)
□	□	Infective endocarditis (感染性心膜炎)	□ □	□ □	Chemotherapy (化学療法) Radiation treatment (放射線治療	□	□	Stomach ulcers (胃潰瘍)
□	□	Congenital heart disease (先天性心疾患)	□	□	Anemia (貧血)	□	□	Arthritis (関節炎)
□	□	Arteriosclerosis (動脈硬化)	□	□	Blood transfusion (輸血)	□	□	Chronic pain (慢性疼痛)
□	□	Coronary artery disease (冠動脈疾患)	□	□	Hemophilia (血友病)	□	□	Diabetes (type or type II) (糖尿病)
□	□	Congestive heart failure (うっ血性心不全)	□	□	High or low blood pressure (高血圧・低血圧)	□	□	Eating disorder (摂食障害)
□	□	Heart attack (心臓発作)	□	□	Anxiety (不安症)	□	□	Infections (感染症)
□	□	Heart Disease (心臓病)	□	□	Depression (うつ病)	□	□	**Hepatitis (肝炎) A/ B/ C**
□	□	Heart murmur (心雑音)	□	□	Epilepsy (癲癇)	□	□	Immune deficiency (免疫性疾患)
□	□	Rheumatic heart disease (リューマチ性心疾患)	□	□	Mental health problem (精神障害)	□	□	Kidney problems (腎臓疾患)
□	□	Stroke (脳卒中)	□	□	Neurological disorders (神経疾患)	□ □	□ □	Osteoporosis (骨粗鬆症) Bisphosphonates (Fosamax)
□	□	Asthma (喘息)	□	□	Post-traumatic stress disorder (心的外傷後ストレス障害)	□	□	Rheumatoid arthritis (リュウマチ性関節炎)
□	□	Bronchitis (気管支炎)	□	□	Traumatic brain injury or concussion (外傷性脳損傷/脳震盪)	□	□	Sexually transmitted infection (性病)
□	□	Emphysema /COPD (肺気腫/ 慢性閉塞性肺疾患)	□	□	**AIDS or HIV infection (エイズ/ HIV 感染)**	□	□	Thyroid problems (甲状腺疾患)
□	□	Tuberculosis (肺結核)	□	□	Lupus (狼瘡)	□	□	Glaucoma (緑内障)

Allergies: (アレルギー)

Y	N		Y	N		Y	N	
□	□	Aspirin (アスピリン)	□	□	Latex (rubber)(ラテックス/ゴム)	□	□	Metals (金属)
□	□	Sedative or sleeping pill (鎮静剤/ 睡眠薬)	□	□	Local Anesthetics (麻酔薬)	□	□	Sulfa drugs (サルファ剤)
□	□	Hay fever (花粉症)	□	□	Penicillin or other antibiotics (ペニシリン/ その他の抗生物質)	□	□	Other (その他)

Medication: (常用薬)

Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below. 上記にはない病気、症状、問題がある場合は、ご記入をお願いします。

For Female, please answer the following: (女性の方は、次の質問にお答えください)

Y	N	
□	□	Are you taking birth control pills? (避妊薬を常用していますか?)
□	□	Are you Pregnant? (妊娠していますか?) If yes, # of weeks (そうであれば、何週目ですか)
□	□	Are you Nursing? (授乳していますか?)

Dental History & Symptoms (歯科履歴及び症状)

Reason for today's visit: (本日の受診理由)
When was your last dental exam? (最後の歯科検診はいつですか?)
When was the last time you had dental x-rays taken? (最後にレントゲンを撮ったのはいつですか?)
Previous Dentist Name: (以前受診されていた歯科医の名前)

Please mark an "X in the box ONLY if this applies to you.

□	Is it hard to open your mouth? (口を開けるのが困難ですか?)	□	Bad breath (口臭)
□	Does it hurt to chew, bite or swallow? (噛んだり飲み込んだりするときに痛みがありますか?)	□	Dry mouth (口が乾く)
□	Do you Clench or grind your teeth? (歯を食いしばったり、歯ぎしりしたりしますか?)	□	Jaw pain (顎が痛い)
□	Does your jaw click, pop or hurt? (顎が外れたり痛みがありますか?)	□	Bleeding gum (歯茎からの出血)
□	Do you have earaches or neck pains? (耳や首に痛みがありますか?)	□	Sensitive to hot/ cold/ sweet (温かいもの/ 冷たいもの/ 甘いものにしみる)
□	Does dental treatment make you nervous? (歯科治療の際に不安になりますか?)	□	Blisters or any other lesions (水泡などの病変)
□ Have you ever experienced any of these sleep-related breathing disorders? (就寝時の呼吸障害を経験した事がありますか?) □ Mouth breathing (口呼吸) □ Snoring (イビキ) □ Trouble breathing during sleep (就寝時の呼吸障害)			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Honda Plaza dental clinic or insurance company to release any information required to process my claims. (Please sign and date blow)

Patient/ Guardian signature: Date:
Dentist signature: Date:

Acknowledgement of receipt of
Notice of privacy and Cancellation policies

I _____, have received a copy of

Honda Plaza Dental Clinic's notice of Privacy and Cancellation Policies.

_____

Name (Please print)

_____

Signature Date

Office use only

On _____, an acknowledgement of receipt of notice of privacy policies form was delivered. The form was not signed due to:

□ Communication barriers which prevented acknowledgement
□ An emergency which prevent acknowledgement
□ A refusal to sign
□ Other

This information is intended as advisory in nature and should be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical systems/ security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program.
Accuracy and completeness are not guaranteed.
The federal HIPPA privacy compliance requirements are explained in this binder, when you develop your HIPPA compliance policy.
Incorporate whatever is necessary to address state law requirement as well.

Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Honda Plaza Dental Clinic.

Honda Plaza Dental Clinic Legal Responsibilities: As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, well be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced and become effective from 08/21/2001.

We reserve the right to modify our privacy policies and the terms of this notice at anytime, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience information regarding how you can contract us is at the bottom of this notice.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualification of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices 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 protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required by Law: Your protected health information may be used or disclosed if required by Law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail / text messages, postcards, letters, or emails.

PATIENT RIGHT

Access: At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected health information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $2.00 for each page and $10 per hour for staff time to locate and copy your protected health information Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions we will follow the agreed restrictions unless an emergency situation dictated otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information communication. You must identify agreed upon explanation of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies, please contact us.

If at ay time you are unsure or concerned that your protected health information has not been protected orif you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative locations, you have the right to bring this issue forward. You may make a 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 Service at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.

Contact Person's Name: Kouichi C. Itoh
Telephone: (213)687-3895
Address: 400 East Second St. Suite #207
City, State, Zip: Los Angeles, CA 90012

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The Federal HIPPA privacy compliance requirements are explained in this binder: When you develop your HIPAA compliance policy, incorporate whatever is necessary to address state law requirements as well.

Appointment Cancellation/ No Show Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation/ No Show Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **72 hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$150.00** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 30 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$150.00** cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation/No Show Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ _____(print name), have received a copy of Honda Plaza Dental Clinic Appointment Cancellation/ No Show Policy.

_____

Signature of Patient Date

Notice of Video Surveillance

Front desk areas of this practice are under video surveillance and recording is in progress. Images may be collected that allow an individual to be identified. The use of video surveillance is for the purposes of controlling theft, ensuring the safety of practice and staff and facilitating the identification of individuals who behave in a disruptive manner or cause damage to practice property.
If you have any questions about video surveillance, please contact Kouichi Itoh DDS.

Surveillance Patient Acknowledgement and Release

For the safety of patients, staff and doctors, this practice is equipped with a non-concealed video surveillance system. Video data is secured with reasonable efforts for your privacy. In certain circumstances, we may share the data with the police and/or other entities as required by law.

I understand that video surveillance may be conducted in all public areas such as waiting areas, examining and treatment rooms and business offices. If cameras are installed in examining and treatment rooms, you will be notified of your rights under HIPAA.

Honda Plaza Dental Clinic retains ownership of video surveillance recordings. The recordings are not considered treatment records and will not be included when transferring dental records to any other medical or dental provider, insurance company or to a parent/legal guardian.

I have read the above information. I understand and agree to the above video surveillance.

_____ _____

Patient Name Relationship

_____

Signature of Patient Date