Welcome to Sekhon Dental, Inc.

We would like to thank you for choosing us for your dental care. Sekhon Dental, Inc. is a boutique family dental practice serving the community since 1979. Please take a moment to complete this package. You can bring it with you on your first appointment or email it to smile@sekhondental.com. Our team is looking forward to providing you with the best dental care.

Again, welcome and thank you for choosing Sekhon Dental, Inc.

Dr. Navjot Sekhon, DDS and Staff

New Patient Checklist

Patient Information Sheet

Consent Completed

Photograph Taken Yes No, why? ________________

Confidential Health History Form

Dental Health History Form

Patient Acknowledgements

Notice of Privacy Practices

Dental Fact Sheet

Sekhon Dental, Inc.
5353 Reyes Adobe Road, Suite A
Agoura Hills, CA 91301
Phone: (818) 991-5004 | Fax: (818) 991-3996
Email: smile@sekhondental.com | Web: sekhondental.com

Patient Information Sheet

PATIENT INFORMATION **Date** **Chart #**

Name (First, Middle and Last Name)	Date of Birth	Social Security #	ID #
Minor: Yes No	Gender	Marital Status	Occupation
Legal Guardian Name:	M F		
Email Address	Home Phone	Cell Phone	Work Phone
Address	City	State	Zip
Employer	Position	How Long?	
Employer Address	City	State	Zip

FINANCIALLY RESPONSIBLE PARTY

Is Patient Responsible? Yes No				
Complete Only if Patient is NOT responsible				
Responsible Party Name (First, Middle and Last Name)	Date of Birth	Social Security #	Gender	Relationship
			M F	
Email Address	Home Phone	Cell Phone		Work Phone
Address (if different from Patient)	City		State	Zip
Employer	Position	How Long?		
Employer Address	City	State		Zip

PRIMARY INSURANCE **Card provided** **No Insurance**

Insured Name (First, Middle and Last Name)	Relationship
DOB	Gender M F
Social Security #	
Address (if different from Patient)	
Employer	Employer Phone
Insurance Company	Phone Number
Group #	Plan
Policy #	Effective Date

SECONDARY INSURANCE **Card provided**

Insured Name (First, Middle and Last Name)	Relationship
DOB	Gender M F
Social Security #	
Address (if different from Patient)	
Employer	Employer Phone
Insurance Company	Phone Number
Group #	Plan
Policy #	Effective Date

Sekhon Dental, Inc.
5353 Reyes Adobe Road, Suite A
Agoura Hills, CA 91301
Phone: (818) 991-5004 | Fax: (818) 991-3996
Email: smile@sekhondental.com | Web: sekhondental.com

FAMILY MEMBERS (who are patients in our practice)

Full Name (First, Middle and Last Name)	Date of Birth	Relationship

EMERGENCY CONTACTS

Contact # 1 (First, Middle and Last Name)	Relationship	Home Phone	Cell	Email
Contact # 2 (First, Middle and Last Name)	Relationship	Home Phone	Cell	Email

Whom may we thank for referring you? _________________________________

How did you hear about our practice? __________________________________

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial, scheduling and communication responsibilities with our practice.

Initials

_______ **Financial Responsibility:** I understand that payments for services should be made when due, and if any payment is not made timely, I may be subject to late fees. I further understand that if I have authorized debits to my account and should a debit not be honored by my bank, I will incur a service charge for each such dishonored debit. I request that all benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the service provider. I understand that I am responsible for all charges for services whether or not paid by insurance. I authorize the service provider to disclose all information necessary to verify my insurance eligibility and secure the payment of benefits.

_______ **Patient Communication:** By providing the number of my land line, cell phone or other wireless device and my email address now or in the future, I expressly consent and agree that Sekhon Dental, Inc. and any of its affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system or otherwise, leave me a voice, prerecorded, or artificial voice message, or send me a text, e-mail, or other electronic message for any purpose related to the servicing or collection of any account that I may establish with Sekhon Dental, Inc., or for other informational purposes related to my account or treatment ("Communication"). I also agree that Sekhon Dental, Inc. and any of its affiliates, agents, service providers or assignees may include my personal information in a Communication. Sekhon Dental, Inc. will not charge for a Communication, but my service provider may. I agree that Sekhon Dental, Inc. may monitor and record any telephone calls to assure the quality of its service or for other reasons.

_______ **Appointments and Cancellations:** We reserve the dentist and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $50 to full service cost or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is 15 minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $50 to full-service cost or deposit to reserve the appointment time again, may be required.

Sekhon Dental, Inc. will be using electronic medical records, including your photograph, to maintain your health care information. Sekhon Dental, Inc. is committed to maintaining the privacy and confidentiality of patient health information in compliance with HIPAA, and will only use your photograph for internal identification purposes.

You may, at any time, withdraw this consent with written notice to Sekhon Dental, Inc.

_______ **Yes.** I agree to have my photograph taken and stored in Sekhon Dental, Inc.'s electronic medical records system. I understand that by checking "Yes" and signing below, I am giving Sekhon Dental, Inc. permission to take and use my photograph in its electronic medical records system for identification purposes.

_______ **No.** I do not wish to have my photograph taken and stored in Sekhon Dental, Inc.'s electronic medical records system.

_______ **Information Verification:** The information provided herein is true and complete to the best of my knowledge. I authorize Sekhon Dental, Inc., or anyone acting on its behalf, to obtain, review and/or share with its designated agents, or any assignee of my account, my credit report for the purpose of evaluating my credit and verifying my identity, or for updating, renewing, servicing, modifying or collecting my account. This authorization is valid as long as any amounts are owed on my account to Sekhon Dental, Inc. or any assignee of my account. I acknowledge that Sekhon Dental, Inc. may report information about my account to consumer reporting agencies and other persons who may legally receive such information. Late payments, missed payments or other defaults on my account may be reflected in my credit report.

By signing below, I acknowledge that I have read, fully understand, and agree to be bound by this consent.

PATIENT SIGNATURE:____ **DATE:** _____________________

RESPONSIBLE PARTY SIGNATURE:__________________________________ **DATE:** _____________________

Sekhon Dental, Inc.
5353 Reyes Adobe Road, Suite A
Agoura Hills, CA 91301
Phone: (818) 991-5004 | Fax: (818) 991-3996
Email: smile@sekhondental.com | Web: sekhondental.com

Patient Acknowledgements

I hereby acknowledge that I have received a copy of

1. Sekhon Dental Inc.'s Notice of Privacy Practice
2. Dental Materials Fact Sheet

Print Name ____

Signature ____

Date ____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name ____

Relationship to Patient ____

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)

Sekhon Dental

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 Nov. 1, 2018 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.

Change of Ownership
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.

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 officials 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, there may be a charge for time spent. 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.

Research
Your health information may be disclosed to researchers for research purposes. In this situation, written authorization is not required as approved by an Institutional Review Board or privacy board.

Fundraising
We may use or disclose demographic information and dates of treatment in order to contact you for fundraising activities. If you no longer wish to receive these communications, notify us at the contact information provided below and we will stop sending further fundraising information.

Questions and Complaints

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

Dr. Navjot Sekhon, DDS
Sekhon Dental, Inc.
Phone: (818) 991-5004 Fax: (818) 991-3996
Email: smile@sekhondental.com
Address: 5353 Reyes Adobe Rd. # A, Agoura Hills, CA 91301

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Sekhon Dental, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.