DENTAL REGISTRATION AND HISTORY

☆ Whom may we thank for referring you? _____

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____

City State Zip

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Union Affiliation: _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship Date

3 PHONE NUMBERS

Home _____ Cell _____ Work _____ Ext _____

Your email address _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin ❑ Local Anesthetic

❑ Barbiturates (Sleeping Pills) ❑ Penicillin

❑ Codeine ❑ Sulfa

❑ Iodine ❑ Other _____

❑ Latex _____

Reason for Today's Visit:

_____

_____

5 HEALTH HISTORY

Physician's Name _____ Date of Last Visit _____

Please mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Fainting or dizziness	❑ Yes	❑ No	Radiation Treatment	❑ Yes	❑ No
Arthritis, Rheumatism	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Respiratory Disease	❑ Yes	❑ No
Artificial Heart Valves	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Artificial Joints	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Problems	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No
Back Problems	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Bleeding Abnormally with Extractions or Surgery	❑ Yes	❑ No	Type _____			Skin Rash	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Special Diet	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Chemical Dependency	❑ Yes	❑ No	HIV Positive	❑ Yes	❑ No	Swelling of Feet or Ankles	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Swollen Neck Glands	❑ Yes	❑ No
Circulatory Problems	❑ Yes	❑ No	Jaw Pain	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Congenital Heart Lesions	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Cortisone Treatments	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Cough, Persistent or Bloody	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Tumor or Growth on Head or Neck	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Nervous Problems	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Do you wear contact lenses?	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Unexplained Weight Loss	❑ Yes	❑ No
			Women: Are you pregnant?	❑ Yes	❑ No			
			Are you nursing?	❑ Yes	❑ No			
			Due Date _____					

Have you ever taken Fosamax (Bisphosphonate), Zometa, Actonel, Boniva, or Aredia? ❑ Yes ❑ No

6 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad Breath	❑ Yes	❑ No	Burning Sensation on Tongue	❑ Yes	❑ No	Loose Teeth or Broken Fillings	❑ Yes	❑ No
Bleeding Gums	❑ Yes	❑ No	Chew on One Side of Mouth	❑ Yes	❑ No	Mouth Breathing	❑ Yes	❑ No
Blisters on lips/mouth	❑ Yes	❑ No	Cigarette, pipe, or Cigar Smoking	❑ Yes	❑ No	Mouth Pain, Brushing	❑ Yes	❑ No
			Clicking or Popping Jaw	❑ Yes	❑ No	Orthodontic Treatment	❑ Yes	❑ No
			Dry Mouth	❑ Yes	❑ No	Pain Around Ear	❑ Yes	❑ No
			Fingernail Biting	❑ Yes	❑ No	Periodontal Treatment	❑ Yes	❑ No
			Food Collection Between the Teeth	❑ Yes	❑ No	Sensitivity to Cold	❑ Yes	❑ No
			Foreign Objects	❑ Yes	❑ No	Sensitivity to Heat	❑ Yes	❑ No
			Grinding Teeth	❑ Yes	❑ No	Sensitivity to Sweets	❑ Yes	❑ No
			Gums Swollen or Tender	❑ Yes	❑ No	Sensitivity when Biting	❑ Yes	❑ No
			Jaw Pain or Tiredness	❑ Yes	❑ No	Sores/Growths in Mouth	❑ Yes	❑ No
			Lip or Cheek Biting	❑ Yes	❑ No			

How often do you floss? _____

How often do you brush? _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

x_____ Date _____

Patient Signature

TO BE FILLED IN BY DOCTOR

MEDICAL HISTORY REVIEWED ON: _____ BY_____

INFORMED CONSENT

I understand that by signing and initialing below, that I request and authorize the procedure(s) to be done, and have read and understand the descriptions of the procedures.

X-RAYS & EXAMINATION

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while x-rays are taken on my teeth, that I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant, radiation exposure poses a serious threat to the life and health of my unborn child. **Pregnant women are required to have a medical release from their medical doctor prior to having x-rays and/or dental treatment.**

_____
Initials

CHANGES IN TREATMENT PLANS

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that, whenever possible, I will be informed of any changes in advance. I give my permission to the dentist to make any changes and additions as necessary.

_____
Initials

DRUGS & MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock.

_____
Initials

I understand that there has been no guarantee or assurance made by anyone in regards to the dental treatment that I have authorized. I also acknowledge that I am responsible for payment of all my dental fees regardless of any dental insurance coverage.

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Witness' Signature_____ Date_____

Valley Circle Family Dental

OFFICE POLICES

_____ • We must have a copy of your insurance card (if applicable) and a photo ID (i.e. driver license, passport) on file.

_____ • Unless an emergency comes up, we will always try to be prompt and we also appreciate you being prompt as well. If you need to reschedule an appointment, please notify us **at least 24 prior to your scheduled appointment time.** Failure to do so will result in a charge of $25.00 per hour scheduled.

_____ • **CONSENT:** I understand that all responsibility for payment for dental services provided in this office for any dependents or myself, is **due and payable at the times services are rendered.** Insurance coverage is only an estimate; the patient is responsible for all treatment costs not covered by insurance.

_____ • For your convenience, we accept cash, checks, Visa, Mastercard, American Express, Discover, and Care Credit.

Please inform the office staff if you have any changes in your health, address, or insurance.

If you have any questions, please feel free to ask.

_____

Printed Name

_____

Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Safeguarding Your Protected Dental Information:

Aesthetic & Family Dental Care is committed to protecting your dental information. In order to provide treatment or to pay for your healthcare, Aesthetic & Family Dental Care will ask for certain health and dental information and that health and dental information will be put into your record.' The record usually contains your symptoms, examination results, x-rays, diagnoses, and treatment. That information, referred to as your dental record, and legally regulated as dental information may be used for a variety of purposes. Aesthetic & Family Dental Care is required to follow the privacy practices described in this Notice, although Aesthetic & Family Dental Care reserves the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new notice by contacting our office.

How Aesthetic & Family Dental Care May Use and Disclose Your Protected Dental Information:

Aesthetic & Family Dental Care employees will only use your dental information when doing their jobs. For uses beyond what Aesthetic & Family Dental Care normally does. Aesthetic & Family Dental Care must have your written authorization unless the law permits or requires it. The following are some examples of our possible uses and disclosures of your dental information.

Uses and Disclosures Relating to Treatment, Payment, or Health and Dental Care Operations:

For treatment: Aesthetic & Family Dental Care may use or share your dental information to approve or deny treatment and to determine if your dental treatment is appropriate. For example, Aesthetic & Family Dental Care's dental care providers may need to review your treatment plan with your healthcare provider or dental specialty provider for medical necessity or for coordination of care.

To obtain payment:

Aesthetic & Family Dental Care may use and share your dental information in order to bill and collect payment for your dental care services and to determine your eligibility to participate in our services. For example, your dental care provider may send claims for payment of dental services provided to you.

For dental care operations:

Aesthetic & Family Dental Care may use and share your dental information to evaluate the quality of services provided, or to our state or federal auditors.

Other Uses and Disclosures o f dental information required or allowed by law:

Information purposes:

Unless you provide us with alternative instructions, Aesthetic & Family Dental Care may send appointment reminders, cancellations and other materials about the program to your home and/or make telephone calls to your home or to other numbers provided to us by you for appointment reminders and/or cancellations.

Required by law:

Aesthetic & Family Dental Care may disclose dental information when a law requires us to do so.

Public health activities:

Aesthetic &Family Dental Care may disclose dental information when required to collect or report information about disease or injury, *or* to report vital statistics to other divisions in the department and other public health authorities.

Dental oversight activities:

Aesthetic & Family Dental Care may disclose dental information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.

Coroners, Medical Examiners, Funeral Directors and Organ Donations:

Aesthetic & Family Dental Care may disclose dental information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.

Avert threat to health or safety:

In order to avoid a serious threat to health or safety, Aesthetic & Family Dental Care may disclose dental information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

Abuse and Neglect:

Aesthetic & Family Dental Care will disclose your dental information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or some other crime. Aesthetic & Family Dental Care may disclose your dental information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Specific government functions:

Aesthetic & Family Dental Care may disclose dental information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

Families, friends or others involved in your care:

Aesthetic & Family Dental Care may share your dental information with people as it is directly related to their involvement in your care or payment of your care. Aesthetic & Family Dental Care may also

share dental information with people to notify them about your location, general condition or death. compensation programs that provide callers or visitors who ask for work-related injuries or illnesses without regard to fault.

Patient Directories:

The dental plan under which you are enrolled does not maintain a directory for disclosure to callers or visitors who ask for you by name. You will not be identified to an unknown caller or visitor without authorization.

Lawsuits, Disputes' and Claims:

If you are involved in a lawsuit, a dispute, or a claim, Aesthetic & Family Dental Care may disclose your dental information in response to a court or administrative order, subpoena, discovery request, investigation or a claim filed on your behalf, or other lawful process.

Law Enforcement:

Aesthetic &,Family Dental Care may disclose your dental information to a law enforcement official for purposes that are required by law or in response to a subpoena.

Request restrictions:

You have a right to request a restriction or limitation on the dental information Aesthetic & Family Dental Care uses or discloses about you. Aesthetic & Family Dental Care will accommodate your request if possible, but is not legally required to agree to the requested restriction. If Aesthetic & Family Dental Care agrees to a restriction, Aesthetic & Family Dental Care will follow it except in emergency situations.

Request Confidential Communications:

You have the right to ask that Aesthetic & Family Dental Care send you information at an alternative address or by alternative means. Aesthetic & Family Dental Care must agree to your request as long as it is reasonably easy for us to do so.

Inspect and copy:

You have a right to see your dental information upon your written request. If you want copies of your dental information, you may be charged a fee for coping, depending on your circumstances. You have a right to choose what portions of your information you want copied andto have prior information on the cost of copying.

Request amendment:

You may request in writing that Aesthetic & Family Dental Care correct or add to your health record. Aesthetic & Family Dental Care may deny the request if Aesthetic & Family Dental Caredetermines that the health information is: (1) correct and complete (21 not created by us and/or not Dart of our records: or (31 not permitted to be disclosed; If Aesthetic & Family Dental Care approves the request for amendment, Aesthetic & Family Dental Care will change the dental information and inform you, and will tell others that need to know about the change in the dental information.

Accounting of disclosures:

You have a right to request a list of the disclosures made of your dental information after April 14, 2003. Exceptions are dental information that has been used for treatment or payment. In addition, Aesthetic & Family Dental Care does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officials or correctional facilities. There will be no charge for up to one such list each year.

Notice: You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request,

For More Information:

If you have questions and would like more information, you may contact the HIPAA Privacy Information Line at 1-410-767-7790.

To Report a Problem about our Privacy Practices:

If you believe your privacy rights have been violated, you may file a complaint.

- You can file a complaint with the Department of Health and Mental Hygiene, Division of Corporate Compliance at 1-866-770-7175.
- You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may call the Department of Health and Mental Hygiene for the contact information.

Aesthetic & Family Dental Care will take no retaliatory action against you if you choose to file a complaint.

Effective Date: This notice is effective on April 14, 2003.

I have reviewed and received the Notice of Privacy Practices.

Name:_____

Signature:_____

Date:_____