

# Patient Registration

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Preferred Name \_\_\_\_\_

## **Responsible Party** *(If someone other than patient)*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone(\_\_\_\_) \_\_\_\_\_ Cell\_(\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Birthday \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver License \_\_\_\_\_

## **Patient Information**

Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Birthday \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_  
Email: \_\_\_\_\_ Employer: \_\_\_\_\_  
Student Status: full time \_\_\_\_\_ part time \_\_\_\_\_  
Preferred Pharmacy \_\_\_\_\_

## **\*\*Please Check ALL Referral Sources That Apply:**

Radio \_\_\_\_\_ Internet \_\_\_\_\_ Facebook \_\_\_\_\_ Mailer \_\_\_\_\_ Care to Share \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Yelp! \_\_\_\_\_ Family/Friend \_\_\_\_\_  
If family member or friend, **who?** \_\_\_\_\_

## **Emergency Contact**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

## **Primary Dental Insurance Information**

Name of Primary Subscriber \_\_\_\_\_ D.O.B. of Primary Subscriber \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group Number \_\_\_\_\_ Member ID Number \_\_\_\_\_  
Ins. Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Primary's Employer \_\_\_\_\_

## **Secondary Dental Insurance Information**

Name of Primary Subscriber \_\_\_\_\_ D.O.B. of Primary Subscriber \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group Number \_\_\_\_\_ Member ID Number \_\_\_\_\_  
Ins. Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Primary's Employer \_\_\_\_\_



# Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes \_\_\_ No \_\_\_ If yes: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? Yes \_\_\_ No \_\_\_ If yes: \_\_\_\_\_

Have you ever had a serious head or neck injury? Yes \_\_\_ No \_\_\_ If yes: \_\_\_\_\_

Are you taking any medications, pills or drugs? Yes \_\_\_ No \_\_\_ If yes: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux? Yes \_\_\_ No \_\_\_ If yes: \_\_\_\_\_

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing bisphosphonates? Yes \_\_\_ No \_\_\_ If yes: \_\_\_\_\_

Are you on a special diet?.....Yes \_\_\_ No \_\_\_

Do you use tobacco?.....Yes \_\_\_ No \_\_\_

\*Women: Are you....

pregnant/trying to get pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_ Taking Oral Contraceptives? \_\_\_\_\_

Are you allergic to any of the following:

Aspirin \_\_\_\_\_ Penicillin \_\_\_\_\_ Codeine \_\_\_\_\_ Acrylic \_\_\_\_\_ Metal \_\_\_\_\_

Latex \_\_\_\_\_ Sulfa Drugs \_\_\_\_\_ Local Anesthetics \_\_\_\_\_ Other? \_\_\_\_\_

Do you use controlled substances?.....Yes \_\_\_ No \_\_\_ If yes: \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed ☐ Yes ☐ No If yes \_\_\_\_\_

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient or Guardian \_\_\_\_\_

Date \_\_\_\_\_



# Dental History

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When was your last dental visit? \_\_\_\_\_ How often did you see your dentist? \_\_\_\_\_

Are you having any dental problems that require immediate attention? \_\_\_\_\_

Do any of the following cause tooth discomfort? Hot \_\_\_\_\_ Cold \_\_\_\_\_ Sweets \_\_\_\_\_ Chewing \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_ Water Jet? \_\_\_\_\_

Do your gums bleed while cleaning? Y / N Do your gums ever feel tender or swollen? Y / N

Do your jaws ever feel tired or ache? Y / N Click or Pop? Y / N Can you chew on both sides of your mouth? Y / N

Comfortably? Y / N Do you have frequent headaches? Y / N Earaches? Y / N

Do you have any problems with sleeping/snoring/have sleep apnea? Y / N \_\_\_\_\_

Have you ever had orthodontic treatment (braces)? Y / N If yes, when? \_\_\_\_\_

Do you lose or break fillings? Y / N Do you usually have many cavities? Y / N Do you have any food Traps? Y / N

Do you have any noticeable wear on your teeth? Y / N Do you have any missing teeth? Y / N

Have they been replaced? Y / N If yes, how? Fixed bridge \_\_\_\_\_ Removable partial \_\_\_\_\_ Full Denture \_\_\_\_\_ Dental Implant \_\_\_\_\_

Are you comfortable with the replacement? Y / N Please describe \_\_\_\_\_

\_\_\_\_\_

How do you feel about the appearance of your smile? \_\_\_\_\_

If there were a simple inexpensive way to whiten your teeth, would you be interested? Y / N

Have you ever had any cosmetic dentistry done to improve your appearance? Y / N

If yes, are you pleased with the result? Y / N Please comment \_\_\_\_\_

\_\_\_\_\_

Have you ever had an unpleasant dental experience? Y / N \_\_\_\_\_

Please add anything you feel is important \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you want from your Dentist/Dental office? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# Financial Policy Agreement

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## Payment For Your Dental Care

It is our policy to have a complete discussion of all fees and obligations prior to treatment so there are never any surprises. We will tell you in advance what expectations for payment there will be at each appointment. Our goal is to provide you with the best treatment that meets your goals for dental health. We believe that goal must include providing you with clarity on the cost of your care, as well as providing options for payment when appropriate.

### Payment Options

- **Payment for dental services is due at the at the time of treatment**

We accept the following payment methods: cash, check, credit card, or debit card. We accept most major credit cards. Returned checks will incur a \$50 service charge.

- **Prepayment Discount**

For those who choose to pay for treatment greater than \$1000 at the time of scheduling, we offer a 5% prepayment courtesy. This courtesy does **not** apply for payments using Care Credit.

- **Third Party Financing**

As an added service, we have formed a relationship with a third party financing company called Care Credit. With Care Credit, you may reduce your dental costs into monthly payments at **0% interest** for up to 12 months. In addition, there is an option to extend payments beyond twelve months for a reasonable monthly interest rate.

- **For Those With Dental Benefits**

We are always happy to assist you in understanding and maximizing all benefits that may reduce your out of pocket investment. As a courtesy, we prepare and submit all necessary forms to your dental benefit administrator. We set up reimbursements to be sent directly to you.

I understand and agree to the above conditions and authorize the release of any dental information necessary to process claims to dental benefit administrators when appropriate.

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Patient, Parent, or Guardian Signature

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Date

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Patient Name (Please Print)



# Privacy Practice Signature

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## Patient Acknowledgement of Receipt of Privacy Practice *(see attached pages)*

\_\_\_\_\_ I Have Received From Pam M. Dassenko, DDS and E. Carrie Ramirez, DDS a Copy of  
The Privacy Practice Notice Sheet.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

## Dental Materials Fact Sheet Signature

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### Patient Acknowledgement of Dental Materials Fact Sheet *(see attached pages)*

\_\_\_\_\_ I have been given the website for facts about fillings / materials.

Dental Materials Fact Sheet website: [www.dbc.ca.gov/formspubs/pub\\_dmfs2004.pdf](http://www.dbc.ca.gov/formspubs/pub_dmfs2004.pdf)

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

cut here-----

**Website address for a copy of Dental Materials Fact Sheet:**

[www.dbc.ca.gov/formspubs/pub\\_dmfs2004.pdf](http://www.dbc.ca.gov/formspubs/pub_dmfs2004.pdf)



# Notice of Privacy Practices

This notice describes how 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 law requires us to maintain the privacy of your health information. The law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice took effect March 26, 2013 and will remain in effect until we replace it. We reserve the right to change our privacy practices and terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the 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 changes. Before we make a significant change in our privacy practices, we will change this notice and make a new notice available upon request. You may request a copy of this notice at any time.

## Types of Uses and Disclosures:

**Treatment:** We may use your health information in treatment or disclose it to a dentist, physician, or other health care provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to federal Privacy Rules for its payment activities.

**Health Care Operations:** We may use and disclose your health information for our health care operations. Health care operations include 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 and credentialing activities. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the compliance or qualification of health care professionals, or detect or prevent health care fraud or abuse.

**On Your Authorization:** 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 can revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. If authorization was for purposes of obtaining insurance coverage, other law gives the insurance company certain rights. Unless you give us a written authorization we cannot use or disclose your health information for any reason except for those described in this notice.

**To Your Family and Friends:** We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with the opportunity to object to our use of disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgement if the disclosure would be in your best interest. We may use professional judgement 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, or other similar form of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, post cards or letters).

**Disaster Relief:** We may use or disclose your health information to a public or private entity authorized by law or its charter to assist in disaster relief efforts.

**Public Benefit:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public health activities, including disease and vital statistic reporting, child abuse reporting; FDA oversight, and to employers regarding work-related illness or injury
- To help report adult abuse, neglect, or domestic violence

You have the right to ask for a restriction on uses of disclosures of information. This office does not have to agree to withhold disclosures except if the following two criteria are met:

- if you ask us not to disclose information about a health care item or service to a health plan for payment or health care operations purposes, and
- we have been paid in full for the item or service by you or by another on behalf of you

**Breach Notification:** We are required by law to notify affected individuals following a breach of unsecured patient information.

**Selling of Private Health Information:** We cannot sell your private health information without your written consent. Consent is also required for certain marketing communications.

