Patient Registration

Name

Last _____First _____ Middle ___ 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:_____

Preferred Pharmacy_____

Student Status: full time_____ part time_____

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_____

Please fill out the insurance portion entirely so we may submit your dental claims and help see that you are reimbursed quickly by your insurance carrier. Although we are an out-of-network provider, we will do everything we can to help our patients reach the maximum benefit from their PPO insurance plan.

Dental Insurance Information

Name of Primary Policy Holder _____ **D.O.B. of Primary Policy Holder** _____

Name of Insurance Company_____

Group Number_____ **Member ID Number**_____

Insurance Company Claims Billing Address_____

City_____ **State**_____ **Zip**_____

Name of Primary Policy Holder's Employer_____

***If you have Secondary Dental Insurance, please inform the office staff.

E. CARRIE RAMIREZ DDS
www.SLOcoastDentist.com

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

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

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.

_____ _____

Patient, Parent, or Guardian Signature Date

_____

Patient Name (Please Print)

Privacy Practice Signature

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

_____ I Have Received From E. Carrie Ramirez, DDS a Copy of The Privacy Practice Notice Sheet.

_____ _____

Signature *Date*

Dental Materials Fact Sheet Signature

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: https://www.dbc.ca.gov/formspubs/pub_dmfs2004.pdf

_____ _____

Signature *Date*

cut here----------

Website address for a copy of Dental Materials Fact Sheet:

https://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.