Vacaville Dental Studio
412 Cernon St. Suite C,
Vacaville, CA 95688 707-448-5339

PATIENT REGISTRATION

Today's Date:_____

PATIENT INFORMATION...

PATIENT'S FIRST NAME	INITIAL	LAST NAME	PREFERS TO BE CALLED
ADDRESS			BIRTHDATE / AGE
CITY	STATE	ZIP	☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE
HOME PHONE	CELL PHONE	WORK PHONE	SOCIAL SECURITY NO.
EMAIL			DRIVER'S LIC. NO.

IF PATIENT IS A MINOR, PLEASE GIVE:	PARENT OR GUARDIAN NAME		RELATIONSHIP
	ADDRESS	CITY	STATE / ZIP
HOME PHONE	CELL PHONE	WORK PHONE	EMAIL
WHO DOES THE CHILD RESIDE WITH? ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER:_____			SOCIAL SECURITY NO.

PLEASE PROVIDE ADDITIONAL CONTACT INFORMATION...

EMERGENCY CONTACT PERSON	PHONE NO.	RELATIONSHIP
ADDRESS	CITY	STATE / ZIP
NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU	PHONE NO.	RELATIONSHIP
ADDRESS	CITY	STATE / ZIP

THE BIGGEST COMPLIMENT OUR PATIENTS GIVE US IS THE REFERRAL OF THEIR FAMILY AND FRIENDS...

WHO MAY WE THANK FOR REFERRING YOU?	ARE THEY A PATIENT HERE?

OTHER:

☐ BUILDING SIGN ☐ MAILER/ ADVERTISEMENT ☐ PLAZA DENTAL CARE WEBSITE

☐ INSURANCE COMPANY ☐ INTERNET SEARCH ☐ _____

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE:

PRIMARY CARRIER	
INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
INSURED'S NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED'S INSURANCE I.D. NO.	GROUP NO
INSURED'S SOCIAL SECURITY NO.	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

SECONDARY CARRIER	
INSURANCE COMPANY NAME	INSURANCE PHONE
EMPLOYER NAME	EMPLOYER PHONE
INSURED'S NAME	
BIRTH DATE	RELATIONSHIP TO PATIENT
INSURED'S INSURANCE I.D. NO.	GROUP NO
INSURED'S SOCIAL SECURITY NO.	
IF STUDENT, COLLEGE NAME	☐ FULL TIME ☐ PART TIME

Please turn over and sign

PATIENT REGISTRATION

ACKNOWLEDGEMENT & CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my, or my dependent's, dental needs.

2. **Regarding Dental Insurance and Co-Pays:**
   It is a courtesy to our patients that we bill your dental insurance. However we do require current & accurate dental insurance information. The balance is your responsibility whether your insurance pays or not. In addition to your estimated co-pay **(paid at the time of treatment)**, if your insurance has not paid in full within 90 days, the balance is your responsibility.

3. **Missed Appointments**
   Your scheduled appointment is time reserved specifically for you. Unless cancelled, ***at least 48 hours in advance***, our policy is to charge a ***minimum*** of $75.00 for missed appointments, or a fee equivalent to the time reserved for you at each missed appointment. Please help us to serve you better by keeping scheduled appointments.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written and/or electronic health records that are individually identifiable as mine, or my dependent's, for the purpose of carrying out my treatment, payment and health care. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I hereby authorize and direct payment of the dental insurance benefits otherwise payable to me for services rendered, directly to Dental Office. In the event that the insurance company misdirects payment to me, I understand that I am responsible to immediately remit such payments to Dental Office.

6. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a $25 late charge per late payment may be added to my account. I further agree to inform the Dental Office of any address or phone number change within 30 days of such a change. In the event I fail to do so I authorize Dental Office to use all due means, including the use of credit history records, to ascertain my new address for billing purposes.

Patient's Signature _____ Date _____

Parent/Responsible Party's Signature _____

Relationship to Patient _____

Witness _____

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DENTAL HISTORY

Welcome! *So that we may provide you with the best possible care please complete both sides of this dental/medical history form. All information is completely confidential.*

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ City _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ **How often do you floss?** _____

Have you ever used, or are you currently using, topical fluoride? ☐ **Yes** ☐ **No**

What other dental aids do you use? (Interplak, toothpick etc.) _____

Do you have any dental problems now ☐ **Yes** ☐ **No**

If yes, please describe _____

Are any of your teeth sensitive to:

Hot or Cold?	Yes ☐ No ☐
Sweets?	Yes ☐ No ☐
Biting or Chewing?	Yes ☐ No ☐
Have you noticed any mouth odors or bad tastes?	Yes ☐ No ☐
Do you frequently get cold cores, blisters, or any other mouth lesions?	Yes ☐ No ☐
Do your gums bleed or hurt?	Yes ☐ No ☐
Have your parents experienced gum disease or tooth loss?	Yes ☐ No ☐
Have you noticed any loose teeth or change in your bite?	Yes ☐ No ☐
Does food tend to get caught between your teeth?	Yes ☐ No ☐

Do You?

Clench or grind your teeth while awake or asleep?	Yes ☐ No ☐
Bite your cheeks, lips or fingernails regularly?	Yes ☐ No ☐
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, etc)	Yes ☐ No ☐
Mouth breathe while awake or asleep?	Yes ☐ No ☐
Have tired jaws especially in the morning?	Yes ☐ No ☐
Snore or have any other sleeping disorders?	Yes ☐ No ☐
Smoke/Chew tobacco or use other tobacco products?	Yes ☐ No ☐
Drink coffee or tea?	Yes ☐ No ☐

Are you satisfied with your teeths appearance?	Yes ☐ No ☐
Do you think your dental health affects your overall health?	Yes ☐ No ☐
Do you think regular professional cleanings are important?	Yes ☐ No ☐

Have you ever had?

Orthodontic Treatment?	Yes ☐ No ☐
Oral Surgery?	Yes ☐ No ☐
Periodontal Treatment?	Yes ☐ No ☐
Your teeth ground or bite adjusted?	Yes ☐ No ☐
A full/partial denture or mouth guard?	Yes ☐ No ☐
How old is it? _____	
A serious injury to the mouth or head?	Yes ☐ No ☐

Have you ever experienced?

Clicking or popping of the jaw?	Yes ☐ No ☐
Pain (joint, ear, side of face)?	Yes ☐ No ☐
Difficulty in opening or closing the mouth?	Yes ☐ No ☐
Difficulty in chewing on either side of mouth?	Yes ☐ No ☐
Headaches, neckaches, shoulder aches?	Yes ☐ No ☐
Sore muscles (neck, shoulders)?	Yes ☐ No ☐

If you could change your teeth?

Whiter?	Yes ☐ No ☐
Straighter?	Yes ☐ No ☐
Remove Space?	Yes ☐ No ☐
Replace silver fillings with white tooth colored fillings?	Yes ☐ No ☐
Repair chipped teeth?	Yes ☐ No ☐
Replace missing teeth?	Yes ☐ No ☐
Replace old crowns that don't match?	Yes ☐ No ☐
Less gums showing?	Yes ☐ No ☐

Do you feel nervous about having dental treatment? Yes No

If so, what's your biggest concern? _____

_____

Have you ever been told to take a pre-medication prior to dental treatment? Yes ☐ No ☐

Is there anything else about having dental treatment that you would like us to know? Yes ☐ No ☐

_____

MEDICAL HISTORY

IF YOU ANSWER YES TO EITHER OF THE TWO QUESTIONS BELOW, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST

HAVE YOU HAD THE FOLLOWING DISEASES OR PROBLEMS?

ACTIVE TUBERCULOSIS _____ ☐ YES ☐ NO COUGH THAT PRODUCES BLOOD _____ ☐ YES ☐ NO

THE FOLLOWING QUESTIONS ARE FOR YOUR BENEFIT AND ASSURE THAT TREATMENT WILL TAKE INTO CONSIDERATION YOUR PAST AND PRESENT HEALTH STATUS. SOME QUESTIONS MAY SEEM UNRELATED TO YOUR DENTAL CONDITION, BUT THEY ARE ALL ASSOCIATED WITH PROPER ORAL HEALTH CARE. PLEASE ANSWER EACH QUESTION.

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ☐ Yes ☐ No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No
3. Are you currently taking any medication, drugs, pills or herbal remedies, including dosages of aspirin? ☐ Yes ☐ No
   If yes, please list name and dosage _____
4. Are you sensitive or allergic to any substance or medication? ☐ Yes ☐ No If yes, which drugs? ☐ Penicillin ☐ Tetracycline
   ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Other. If other, what drugs? _____
5. Have you ever taken prescription medications for weight loss (diet pills)? ☐ Yes ☐ No
   If yes, did you take any of the following: (circle if yes) ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other _____
   If yes to any of the above, did you have a medical exam for heart issues? ☐ Yes ☐ No
6. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ Yes ☐ No
7. Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No

8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

A.I.D.S./H.I.V. Positive	Yes No	Diabetes	Yes No	Liver Disease/Yellow Jaundice	Yes No
Anemia	Yes No	Diet (Special/Restricted)	Yes No	Mitral Valve Prolapse	Yes No
Arthritis/Rheumatism	Yes No	Difficulty Swallowing	Yes No	Nervous Disorders	Yes No
Artificial Heart Valve/Pacemaker	Yes No	Drug Addiction	Yes No	Nervous/Anxious	Yes No
Artificial Joints (hip,knee,etc)	Yes No	Emphysema	Yes No	Neurological Disorders	Yes No
Artificial Prosthesis	Yes No	Epilepsy or Seizures	Yes No	Osteoporosis	Yes No
Asthma	Yes No	Excessive Bleeding	Yes No	Psychiatric/Psychological Care	Yes No
Blood Disease	Yes No	Fainting or Dizzy Spells	Yes No	Radiation Therapy	Yes No
Blood Transfusion	Yes No	Glaucoma	Yes No	Rheumatic Fever	Yes No
Bruise Easily	Yes No	Hay Fever/Allergy/Hives	Yes No	Scarlet Fever	Yes No
Cancer, Tumors, Growths	Yes No	Head Injuries	Yes No	Sickle Cell Disease	Yes No
Cerebral Palsy	Yes No	Heart (Surgery, Disease, Attack)	Yes No	Sinus Trouble	Yes No
Chemotherapy	Yes No	Heart Failure	Yes No	Stroke	Yes No
Chest Pain	Yes No	Heart Murmur	Yes No	Swollen Ankles	Yes No
Chicken Pox	Yes No	Hemophilia	Yes No	Thyroid Problems/Disease	Yes No
Chronic Cough	Yes No	Hepatitis A B C (circle)	Yes No	Tonsillitis	Yes No
Cold Sores/Fever Blisters	Yes No	Herpes	Yes No	Tuberculosis	Yes No
Congenital Heart Lesions	Yes No	High/Low Blood Pressure	Yes No	Ulcers	Yes No
Contact Lenses	Yes No	Kidney Trouble/Disease	Yes No	Venereal Disease	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Other _____	Yes No

9. Have you lost or gained more than 10 pounds in the past year ..... Yes ☐ No ☐
10. Do you have, or have you had any disease, condition, or problem not listed? ..... Yes ☐ No ☐
    If yes, please list: _____

11. Women: Are you pregnant or think you could be pregnant? ☐ Yes _____ Months ☐ No Nursing? Yes ☐ No ☐
12. Do you use birth control prescriptions? ..... Yes ☐ No ☐
13. Do you have any problems associated with your menstrual period? ..... Yes ☐ No ☐

I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

Initial History Review BP _____ Pulse _____

Dentist Signature _____ Date _____

Year 2	Date _____ Signature _____ Changes in Health _____	Date _____ Pulse _____ Reviewed By _____ DDS
Year 3	Date _____ Signature _____ Changes in Health _____	Date _____ Pulse _____ Reviewed By _____ DDS

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DISCLOSURE OF HEALTH INFORMATION

Name: _____

Date of Birth: _____

SSN: _____

I understand that as part of my healthcare, the office of Plaza Dental Care originates and maintains health records describing my health history, account billing, examinations, diagnoses, treatment and any plans for future care treatment.

I request the following restrictions to the use or disclosure of my health information:

_☐_ **Patient Only**

_☐_ **Specialists** – If needed, necessary treatment and personal information (insurance, phone number).

_☐_ **Over 18 Years Old** – If patient is 18 years old and wants to disclose information to parents.

_☐_ **Family Member:**

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship"** _____

Signature: _____ Date: _____

Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a $25.00 service fee.

Service Charge

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.50 for a minimum balance of $25.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. Please be advised that there is a $50.00 fee charged for missed or broken appointments without 24 hours notice. To avoid this charge, kindly give us a minimum of 24 hours notice for any appointment cancellation. Feel free to contact us at any time with questions you may have.

X-Ray/Records Release

There is a fee of $25.00 for any release of X-rays and/or records.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I hereby authorize payment directly to First Dental of Bluffton of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to First Dental of Bluffton to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- 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 healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or 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 judgment of whether the disclosure would be in your best interest. We may 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. 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.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders

of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of August 31, 2015, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S.

Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize First Dental of Bluffton to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
If signing on behalf of someone, explain your relationship to the patient:	

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form:			
Describe your good faith effort to obtain the individual's signature on this form:			
Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date: / /