

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

# PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE				<b>1</b>
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME		FIRST	M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		<b>2</b>
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

ACCOUNT INFORMATION		<b>4</b>
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

GETTING TO KNOW YOU		<b>3</b>
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:		
RELATIONSHIP:		
YOU WERE REFERRED TO US BY		
NAME:		
PERSON TO CONTACT FOR EMERGENCY		
NAME:		
CELL NUMBER		
HOME NUMBER		
ADDRESS		
CITY	STATE	ZIP

## CONSENT FOR TREATMENT

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 (name of patient) \_\_\_\_\_'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. 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 agree to be responsible for payment of all services rendered on my behalf or my dependents. 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 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.
- 6 Cell Phone:  I consent to the dental practice using my cell phone number to (choose one or both)  call or  text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Patient Name

# MEDICAL HISTORY

Patient Account No.

Medical Alert

- Physician's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Have you had any medical care within the past two years? ..... Yes No  
Describe \_\_\_\_\_
- Have you taken any medication or drugs during the past two years? ..... Yes No  
If yes, please list name and dosage \_\_\_\_\_
- Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No  
If yes, please list name and dosage \_\_\_\_\_
- Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... Yes No  
If yes, please list name and dosage \_\_\_\_\_
- Are you aware of having an allergic (or adverse) reaction to any substance or medication? ..... Yes No  
If yes, please specify \_\_\_\_\_
- Have you been a patient in the hospital during the past five years? ..... Yes No
- Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

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

- Have you lost or gained more than 10 pounds in the past year? ..... Yes No
- Do you have or have you had any disease, condition, or problem not listed? ..... Yes No  
If yes, please list: \_\_\_\_\_
- Women:** Are you pregnant or think you could be pregnant? Yes \_\_\_\_\_ Months No **Nursing?** Yes No
- Do you use birth control prescriptions? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. 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 change in my health or medication.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### History Review

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name

DENTAL HISTORY

Patient Account No.

Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental 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 \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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 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 sores, blisters or any other oral 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 become caught in between your teeth? ..... Yes No

If yes, where \_\_\_\_\_

Do you:

Clench or grind your teeth while awake or asleep? ..... Yes No

Bite your lips or cheeks regularly? ..... Yes No

Hold foreign objects with your teeth? (pencils, pipe, 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

Do you feel nervous about having dental treatment? ..... Yes No

Please describe \_\_\_\_\_

Have you ever had an upsetting dental experience? ..... Yes No

Please describe \_\_\_\_\_

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

If yes, please describe \_\_\_\_\_

(Please complete other side)

**Notice of Privacy Practices - The DentisTree**  
77 E. 7<sup>th</sup> Street, Suite A, Upland, Ca 91786 ▪ (909) 985-6118 ▪ TheDentisTree.com

Effective March 23, 2018

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please contact our office. We are required by law to: Maintain the privacy of your protected health information, give you this notice of our duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

**HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:**

Described as follows are the ways we may use and disclose health information that identifies you (Health Information, or PHI). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

**Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**Payment.** We may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.

**Health Care Operations.** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.

**Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.** We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non health-related products or services that are subsidized by a third party without your authorization.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

**Fundraising and Marketing.** Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.

**Other Uses.** Other uses and disclosures of Health Information not contained in this Notice may be made only with your authorization.

**SPECIAL SITUATIONS:**

**As Required by Law.** We will disclose Health Information when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

**Workers' Compensation.** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosures to

prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

**YOUR RIGHTS:** You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. **We are not required to agree to all such requests.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, [www.TheDentistTree.com](http://www.TheDentistTree.com). To obtain a paper copy of this notice please request it in writing.

**Right to Electronic Records.** You have the right to receive a copy of your electronic health records in electronic form.

**Right to Breach Notification.** You have the right to be notified if there is a Breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

**CHANGES TO THIS NOTICE:** We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

**COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

I acknowledge having been provided this Notice.  
Signed: \_\_\_\_\_

Privacy Officer: Lorena Cairo, (909) 985-6118, [Smiles4All77@gmail.com](mailto:Smiles4All77@gmail.com)



## Acknowledgement of Receipt of Privacy Practices (HIPPA)

I acknowledge that I have received a copy of The DentisTree's **HIPPA Notice of Privacy Practices**.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient Signature

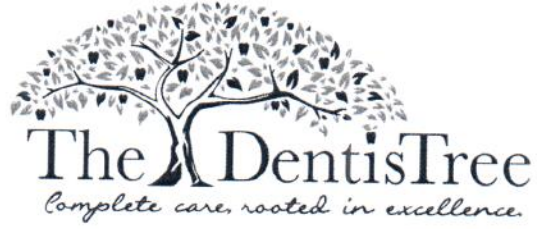
\_\_\_\_\_  
Date

OR

\_\_\_\_\_  
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

Parent     Guardian     Power of Attorney     Other: \_\_\_\_\_



Name \_\_\_\_\_

Date \_\_\_\_\_

How did you learn about our practice? *(Please check all that apply)*

Referral – Patient                      Name: \_\_\_\_\_

Referral – Staff                         Name: \_\_\_\_\_

Referral - Dentist/Dr.                 Name: \_\_\_\_\_

Our Website

Internet Search

Insurance Company                      Which Insurance? \_\_\_\_\_

Advertisement                            Which Publication? \_\_\_\_\_

Other  
\_\_\_\_\_