

Dental Registration and History



Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Birthdate _____ Age _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____



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. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient



Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

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

Name _____ Relationship _____

Home (_____) _____ Work Phone (_____) _____



Dental History

Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No	



Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

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

- | | | | | | |
|--|--|-----------------------|--|---------------------------------|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Do you wear contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Blood Thinners

Women:

Are you pregnant? Yes No Due date _____ Are you nursing? Yes No
Taking birth control pills? Yes No



Medications

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____



Allergies

- | | |
|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |



Updates *(To be filled in at future appointments)*

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



PARC CENTER DENTAL GROUP

77-564 Country Club Dr. • Suite 350

Palm Desert, California 92211

(760) 772-7082

Nurturing One Smile At A Time

We wish take this opportunity and welcome you to our practice. We look forward to working with you in maintaining your dental health. Our goal is to nurture one smile at a time. Our promise is to provide you with dental care of the highest quality. We have the tools and technology to improve your smile, easily and comfortably. Our experienced staff work together as a team to give you exceptional quality treatment.

We accept most insurance plans and will assist you in determining benefits and patient portions. For your convenience, we accept cash and checks, Visa, MasterCard, and Discover cards. We also accept Care Credit and Capitol One cards and provide Care Credit and Capitol One application forms right in our office.

When you arrive for your first visit at Parc Center Dental, your initial exam will last approximately one hour. All necessary x-rays will be taken and we will provide an evaluation that will outline your existing dental problems and proposed treatment.

We are here Monday thru Thursday 8:00 to 5:00, Fridays 8:00 to 1:00. We also provide a twenty four emergency service where you are able to reach one of the Doctors for assistance.

If you have any concerns or questions at any time, please do not hesitate to call our office. Any one of our dedicated staff members will be happy to help you.

We look forward to seeing you at your appointment.

Sincerely,

Parc Center Dental Group

PARC CENTER DENTAL FINANCIAL POLICY

Thank you for choosing us as your general Dentist care provider. We are dedicated to serving your dental needs with the best professional advice, care and service. Please understand that payment of your bill is part of your treatment. We sincerely hope your visit will be a pleasant and rewarding experience.

REGARDING PAYMENT:

Full payment is due at the time services are rendered unless prior arrangements have been made with the financial coordinator Dennise. We accept all credit cards, checks, cash and Care Credit.

REGARDING INSURANCE:

Your insurance policy is a contract between you and your insurance benefit company. It is your responsibility to know your insurance policy rules, limitations and benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf.

MISSED APPOINTMENTS:

Appointment time is reserved exclusively for scheduled patients only. We request a 24 hour advance notice for cancelling and rescheduling your appointment. Your account will be charged a \$25 broken appointment fee for repeatedly missed appointments without proper notification.

I understand and accept the financial and dental insurance policies listed above.

PATIENT SIGNATURE

DATE

DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES

[45 CFR 164.512 (b)]

Background

The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protect health information to carry out their public health mission. The Rule also recognizes that public health reports made by covered entities are an important means of identifying threats to the health and safety of the public at large, as well as individuals. Accordingly, the Rule permits covered entities to disclose protected health information without authorization for specified public health purposes.

How the Rule Works

General Public Health Activities. The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports or the purpose of preventing or controlling disease, injury, or disability. This would include, for example, the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions. See 45 CFR 164.512(b)(1)(i). Also, covered entities may, at the direction of a public health authority, disclose protected health information to a foreign government agency that is acting in collaboration with a public health authority. See 45 CFR 164.512(b)(1)(i). Covered entities who are also a public health authority may use, as well as disclose, protected health information for these public health purposes. See 45 CFR 164.512(b)(2).

A “public health authority” is an agency or authority of the United States government, a State, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency. See 45 CFR 164.501. Examples of a public health authority include State and local health departments, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and the Occupational Safety and Health Administration (OSHA).

Generally, covered entities are required reasonably to limit the protected health information disclosed for public health purposes to the minimum amount necessary to accomplish the public health purpose. However, covered entities are not required to make a minimum necessary determination for public health disclosures that are made pursuant to an individual’s authorization, or for disclosures that are required by other law. See 45 CFR 164.502(b). For disclosures to a public health authority, covered entities may reasonably rely on a minimum necessary determination made by the public health authority in requesting the protected health information. See 45 CFR 164.514(d)(3)(iii)(A). For routine and recurring public health disclosures, covered entities may develop standard protocols, as part of their minimum necessary policies and procedures, that address the types and amount of protected health information that may be disclosed for such purposes. See 45 CFR 164.514(d)(3)(i).

Other Public Health Activities. The Privacy Rule recognizes the important role that persons or entities other than public health authorities play in certain essential public health activities. Accordingly, the Rule permits covered entities to disclose protected health information, without authorization, to such persons or entities for the public health activities discussed below.

Child abuse or neglect. Covered entities may disclose protected health information to report known or suspected child abuse or neglect, if the report is made to public health authority or other appropriate government authority that is authorized by law to receive such reports. For instance, the social services department of a local government might have legal authority to receive reports of child abuse or neglect, in which case, The Privacy Rule would permit a covered entity to report such cases to that authority without obtaining individual authorization. Likewise, a covered entity could report such cases to the police department when the police department is authorized by law to receive such reports. See CFR 164.512(b)(1)(ii). See also CFR 512(c) for information regarding disclosures about adult victims of abuse, neglect, or domestic violence.

Quality, safety or effectiveness of a product or activity regulated by the FDA

Covered entities may disclose protected health information to a person subject to FDA jurisdiction, for public health purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity for which that person has responsibility. Examples of purposes or activities for which such disclosures may be made include, but are not limited to:

- Collecting or reporting adverse events (including similar reports regarding food and dietary supplements), product defects or problems (including problems regarding use or labeling), or biological product deviations;
- Tracking FDA-regulated products;
- Enabling product recalls, repairs, replacement or lookback (which includes
- Locating and notifying individuals who received recalled or withdrawn
- Products or products that are the subject of lookback); and
- Conducting post-marketing surveillance.

See 45 CFR 164.512(b)(1)(iii). The “person” subject to the jurisdiction of the GDA does not have to be a specific individual. Rather, it can be an individual or an entity, such as a partnership, corporation, or association. Covered entities may identify the party or parties responsible for an FDA-regulated product from the product label, from written material that accompanies the product (known as labeling), or from sources of labeling, such as the Physician’s Desk Reference.

Persons at risk of contracting or spreading disease. A covered entity may disclose protected health information to a person who is at risk of contracting or spreading a disease or condition if other law authorizes the covered entity to notify such individuals as necessary to carry out public health interventions or investigations. For example, a covered health care provider may disclose protected health information as needed to notify a person that (s)he has been exposed to a communicable disease if the covered entity is legally authorized to do so to prevent or control the spread of the disease. See 45 CFR 164.512(b)(1)(iv).

Workplace medical surveillances. A covered health care provider who provides a health care service to an individual at the request of the individual’s employer, or provides the service in the capacity of a member of the employer’s workforce, may disclose the individual’s protected health information to the employer for the purposes of workplace medical surveillance or the evaluation of work-related illness and injuries to the extent the employer needs that information to comply with OSHA, Mine Safety and Health Administration (MSHA), or the requirements of State laws having a similar purpose. The information disclosed must be limited to the provider’s findings regarding such medical surveillance or work-related illness or injury. The covered health care provider must provide the individual with written notice that the information will be disclosed to his or her employer (or the notice may be posted at the worksite if that is where the service is provided). See 45 CFR 164.512(b)(1)(v).



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SECTION A: PATIENT

NAME _____

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE
AND DENTAL MATERIAL FACT SHEET.**

SIGNATURE _____

DATE: _____

**SECTION B: GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT
AND SIGNATURE OF RECEIPT OF INFORMATION.**

**DESCRIBE YOUR GOOD FAITH EFFORT TO OBTAIN THE INDIVIDUAL'S
SIGNATURE ON THIS FORM:**

**DESCRIBE THE REASON WHY THE INDIVIDUAL WOULD NOT SIGN THIS
FORM:**

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT:

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____ **TITLE:** _____