

## Patient Registration

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Sex: M F      Marital Status: Married Single Divorced Separated Widowed

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Parent/ Responsible party if Minor: \_\_\_\_\_

Employer: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

**Primary Dental Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

### Physician or Clinic

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

### Previous Dentist

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**Consent:** The undersigned hereby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risks including temporary or permanent numbness. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine due and payable at time services are rendered. I further understand that any outstanding balance past 60 days is my responsibility whether insurance benefits apply or not. In the event that I do not pay my balance in full I (we) promise to pay legal interest on the indebtedness together with any collection costs and reasonable legal fees as may be required to effect collection of this note. **I also understand that if I miss or break an appointment without 72 hours' notice (not including weekends) to the Doctor, I will be charged up to \$150 per hour missed.**

I also assign all insurance benefits to the Doctor.

Patient Signature (Guardian if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_

## Medical History

**This Medical History is confidential and necessary for our files and for your health!**

**Please CIRCLE EACH appropriate answer (leave blank if you do not understand the question)**

Yes No Is your general health good?    Date of last Medical exam: \_\_\_\_\_    Date of last Dental exam: \_\_\_\_\_  
Yes No Has there been a change in your health in the past year? \_\_\_\_\_  
Yes No Are you currently being treated by a physician? For? \_\_\_\_\_  
Yes No Have you been hospitalized or had a serious illness in the past 3 years? \_\_\_\_\_

### **HAVE YOU EXPERIENCED....**

Yes No Chest Pain?	Yes No Swollen Ankles?	Yes No Shortness of Breath?
Yes No Recent Weight Loss?	Yes No Persistent Cough?	Yes No Coughing up Blood?
Yes No Bruise Easily?	Yes No Fever/ Night Sweats?	Yes No Bleeding Problems?
Yes No Sinus Problems?	Yes No Difficulty Swallowing?	Yes No Diarrhea/ Bloody Stools?
Yes No Frequent Vomiting	Yes No Skin Diseases?	Yes No Blood in Urine?
Yes No Metal Allergies?	Yes No Headaches?	Yes No Fainting/ Dizzy Spells?
Yes No Blurred Vision?	Yes No Seizures?	Yes No Excessive Thirst/ Urination?
Yes No Latex Allergy?	Yes No Dry Mouth?	Yes No Stomach Problems/ Ulcers?
Yes No Joint Pain/ TMJ?	Yes No Hearing Problems?	

### **DO YOU HAVE OR HAVE YOU HAD....**

Yes No Heart Murmur?	Yes No Yellowing/ Jaundice?	Yes No Mitral Valve Prolapse?
Yes No HIV/ AIDS?	Yes No Tumors/ Cancer?	Yes No Heart Disease/ Heart Attack?
Yes No Heart Defects?	Yes No Arthritis/ Rheumatism?	Yes No Rheumatic Fever?
Yes No Eye Diseases?	Yes No Blood Disorders?	Yes No Anemia?
Yes No Stroke?	Yes No High Blood Pressure?	Yes No Scarlet Fever?
Yes No TB/ Emphysema?	Yes No Hepatitis? Type _____	Yes No Sexually Transmitted Diseases?
Yes No Fever Blisters?	Yes No Herpes?	Yes No Kidney/ Bladder Disease?
Yes No Thyroid/Adrenal Disease?	Yes No Diabetes?	Yes No Artificial Joints/ Pins/ Screws?
Yes No Pacemaker?	Yes No Blood Transfusion?	Yes No Prescription for Fenphen/ Redux?
Yes No Prosthetic Heart Valve?	Yes No Psychiatric Care?	Yes No Surgeries? If so, what _____
Yes No Radiation Treatments?	Yes No Contact Lenses?	Yes No Sleep Apnea?

### **DO YOU/ HAVE YOU....**

Yes No Snore?  
Yes No Often feel tired, fatigued or sleepy during the daytime?  
Yes No Stop breathing during your sleep?

### **ARE YOU TAKING....**

Yes No Drugs/ Medications? \_\_\_\_\_  
Yes No Recreational Drugs? \_\_\_\_\_  
Yes No Tobacco(any form)? \_\_\_\_\_  
Yes No Alcohol? \_\_\_\_\_

**PLEASE LIST ANY POSSIBLE FOOD OR MEDICATION ALLERGIES OR ANY OTHER ILLNESS NOT LISTED ON THIS FORM:**

\_\_\_\_\_  
\_\_\_\_\_

### **WOMEN ONLY....**

Yes No Are you Pregnant? How Far Along? \_\_\_\_\_  
Yes No Are you Nursing?  
Yes No Are you taking Birth Control Pills?

**To the best of my knowledge, I have answered every question on this form completely and accurately. I will inform my dentist of any change in my health and/ or medication.**

Patient/ Parent/ Guardian Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Reviewing Doctor's Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

---

# Palo Alto Dental Wellness

## NOTICE OF PRIVACY PRACTICES

---

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU 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**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (11/01/2013), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. 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 the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

---

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, 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 may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

---

## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.75 for each page, \$25 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

---

---

# Palo Alto Dental Wellness

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices. I authorize Palo Alto Dental Wellness to leave me confidential voice messages at my preferred contact phone number, and emails at the preferred email address given. I understand that I will only be contacted when prompted or when necessary to my dental health. I also understand that if I wish to change the way I am contacted, I must do so in writing.

---

{Please Print Name of Everyone Applicable}

---

{Signature of Patient/ Parent/ Guardian}

---

{Date}

I \_\_\_\_\_ Give permission/consent to PADW to disclose my private records to the following people/person \_\_\_\_\_ , \_\_\_\_\_

Signature of Patient:

Date:

---