# PATIENT REGISTRATION AND HEALTH HISTORY

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION**

## PERSONAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU, START HERE

| | | | | |
|---|---|---|---|---|
| Date | Last Name | First Name | | |
| Spouse Full Name | | | | |
| Address | | | | |
| City | | State | Zip Code | |
| Home Phone Number | Cell Phone Number | | | |
| Birthdate | Age | Male | Female | |
| Married | Single | Divorced | Widowed | Other |
| Social Security Number | Email Address | | | |

IF THIS APPOINTMENT IS FOR YOUR CHILD, START HERE

| | | | |
|---|---|---|---|
| Date | Last Name | First Name | |
| Address | | | |
| City | | State | Zip Code |
| Home Phone Number | Social Security Number | | |
| Birthdate | Age | Male | Female |
| School | | Grade | |
| *IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO* | | | |

## DENTAL INSURANCE

| | | |
|---|---|---|
| PRIMARY CARRIER | | |
| Insurance Company | Group Number | |
| Employee | | |
| Date of Birth | Date Employed | Union or Local Number |
| Employee Number | Employee Social Security Number | |
| SECONDARY CARRIER | | |
| Insurance Company | Group Number | |
| Employee | | |
| Date of Birth | Date Employed | Union or Local Number |
| Employee Number | Employee Social Security Number | |

 

## ACCOUNT INFORMATION

| | | |
|---|---|---|
| PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT | | |
| Name | | |
| Birthdate | Social Security Number | |
| Address | | |
| City | State | Zip Code |
| Phone Number | Email Address | |
| SPOUSE | | |
| Name | | |
| Birthdate | Social Security Number | |
| Occupation | | |
| EMPLOYER | | |
| Company/Organization/Business Name | | |
| Business Address | | |
| Business Phone Number | Extension | |

## GETTING TO KNOW YOU

| | | |
|---|---|---|
| IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? | | |
| Name | Relationship | |
| REFERRED TO US BY | | |
| Name | | |
| EMERGENCY PERSON TO CONTACT | | |
| Name | | |
| Address | | |
| City | State | Zip Code |
| Phone Number | Email Address | |
| CLOSEST RELATIVE NOT LIVING WITH YOU | | |
| Name | | |
| Address | | |
| City | State | Zip Code |
| Phone Number | Email Address | |

 

## MEDICAL HISTORY

| | YES | NO |
|---|---|---|
| 1. Are you having pain or discomfort at this time? | | |
| 2. Have you been a patient in the hospital during the past two years? | | |
| 3. Have you been under the care of a medical doctor during the past two years? | | |

| Physician's Name | Phone Number | | |
|---|---|---|---|
| Address | City | State | Zip Code |

| | YES | NO |
|---|---|---|
| 4. Have you taken any medication or drugs during the past two years? | | |
| 5. Are you now taking any medication, drugs or pills? | | |

If yes, please list:

| | YES | NO |
|---|---|---|
| 6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? | | |

If yes, please list:

7. Indicate which of the following you have had or have at present. Check "yes" or "no" for each item.

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Heart Failure | | | Artificial Joints (hip, knee, etc.) | | |
| Heart Disease or Attack | | | Kidney Trouble | | |
| Angina Pectoris | | | Ulcers | | |
| Congenital Heart Disease | | | Diabetes | | |
| Heart Murmur | | | Thyroid Problems | | |
| High Blood Pressure | | | Glaucoma | | |
| Arteriosclerosis | | | Cosmetic Surgery | | |
| Mitral Valve Prolapse. | | | Emphysema | | |
| Artificial Heart Valve | | | Chronic Cough | | |
| Heart Pacemaker | | | Tuberculosis | | |
| Heart Surgery | | | Asthma | | |
| Rheumatic Fever | | | Hay Fever | | |
| Arthritis | | | Allergies or Hives | | |
| Rheumatism | | | Sinus Trouble | | |
| Cortisone Medicine | | | Radiation Therapy | | |
| Drug Addiction | | | Chemotherapy | | |

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Stroke | | | Hepatitis A (infectious) | | |
| Hepatitis B (serum) | | | Bruise Easily | | |
| Venereal Disease | | | Liver Disease | | |
| A.I.D.S. | | | Yellow Jaundice | | |
| H.I.V. Positive | | | Epilepsy or Seizures | | |
| Cold Sores/Fever Blisters | | | Fainting or Dizzy Spells | | |
| Blood Transfusion | | | Nervousness | | |
| Hemophilia | | | Psychiatric Treatment | | |
| Anemia | | | Developmentally Disabled | | |
| Sickle Cell Disease | | | | | |

| | YES | NO |
|---|---|---|
| 8. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? | | |
| 9. Do your ankles swell during the day? | | |
| 10. Do you use more than two pillows to sleep? | | |
| 11. Have you lost or gained more than 10 pounds in the past year? | | |
| 12. Do you ever wake up from sleep and feel short of breath? | | |
| 13. Are you on a special diet? | | |
| 14. Has your medical doctor ever said you have a cancer or tumor? | | |
| 15. Do you have, or have you had, any disease, condition, or problem not listed? | | |

If yes, please list:

**FOR WOMEN ONLY**

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Are you pregnant? | | | Are you nursing? | | |
| If yes, what month? | | | Are you taking birth control pills? | | |

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature

Date

DosSantos Dental

**CONSENT:**

1. 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 the patient's dental needs
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of Patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that 1-1/2% finance charge (18% APR) may be added to my account.

| | |
|---|---|
| Patient | Date |
| Witness | Date |
| Parent or Responsible Party | Date |
| Relationship to Patient | |


# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse to Sign This Acknowledgement, however in refusing we will not be allowed to process your insurance claims.***

I, _____, have received a copy of DosSantosDental Notice of Privacy Practices.

_____
[Please Print Name]

_____
[Signature]

_____
[Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

**Personal Representative's name**

Relationship to Patient _____

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

# Mauricio DosSantos DDS

## Financial Policy

Thank you for choosing DosSantos Dental as your dental health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing a doctor

FULL PAYMENT OR INSURED PATIENT'S PORTION IS DUE AT TIME OF SERVICE

### Payment for Services

For your convenience, we accept cash, checks, Visa, MasterCard, American Express or Discover Card. We also offer no interest payment plan through Care Credit & other outside financial groups (terms apply) and pre-payment courtesies. We will be happy to help you process your insurance claim forms at no additional cost and we will accept assignment of benefits where allowed. However, we must have your completed insurance form, copy of your insurance card and a provider benefit booklet at your first visit. The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied.

Account Balances older than 90 days and returned checks will be subject to an interest charge of 1.5% per month. There is a $30.00 charge for returned checks.

### Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party of that contract.
2. Our fees are generally considered to fall within the acceptable range by most Companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, 80%) of "U.C.R." which means usual, customary and reasonable by most companies. (This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard of cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must have a benefit booklet to help you determined your benefits.

### Missed Appointments

**Missed appointments without a 48 hour notice are subject to a charge minimum of $75. Our policy is to charge for missed appointments at the rate of a normal office visit. Please help us better serve you by keeping scheduled appointments.**

Thank you for understanding our Financial Policy. We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Please let us know if you have questions or concerns.

### I have read, understand, and agree to this Financial Policy.

_____ **Date** _____

**Signature of Patient**

_____ **Date** _____

**Signature of Responsible Party**

# Notice of Privacy Practices

**This Notice describes how your 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 laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect 9/22/2013, 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 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. For more information about our privacy practices or additional copies of this Notice, please contact us (contact information below).

### HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

**Treatment**: We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

**Payment:** We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

**Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, 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 is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

**Unsecured Email**: We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

**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 may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

**Change of Ownership**: If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.
**Required by Law**: We may use or disclose your health information when we are required to do so by law.
**Public Health**: We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.
**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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.
**Appointment Reminders**: We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.
Sign In Sheet and Announcement: Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.
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**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 contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies ($5/page) and staff time ($50/hr). You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.
**Disclosure Accounting**: You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.
**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 of how payments will be handled under the alternative means or location you request.
**Breach Notification**: In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.
**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 circumstance**s.**

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**QUESTIONS AND COMPLAINTS:**

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: DosSantos Dental Privacy Practice Representative/Office manager

Telephone: 1-909-790-1951 Fax: 1-909-790-1561

E-mail: Rialto@DosSantosDental.com,

Address: 745 N. Riverside Ave. Rialto, CA 92376

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

# Mauricio DosSantos DDS

## Permission to Share Information

We take your privacy seriously and are required by law to receive your permission to share any information regarding your account. You are not required to complete or sign this form. By completing this form you give permission to the staff and doctors at Mauricio DosSantos DDS to share the following records with the person(s) listed below.

**Person(s) allowed to receive information:**

_____

_____

**Please check information you want to be accessible to person(s) listed:**

- ☐ **All account/dental information**
- ☐ **Other**
  - ☐ **Financial**
  - ☐ **Treatment Plan**
  - ☐ **Previous Dental work**

We will continue to share the information listed with the person(s) you have listed until such time as you notify us otherwise. You may contact us at any time to have us discontinue sharing this information.

Print Name:_____

Signature:_____

Date:_____