DENTAL REGISTRATION & HISTORY

PATIENT INFORMATION

Name ______________________________ How would you like to be addressed? ______________
Last First Middle

Address ______________________________ City ______________ State _______ Zip _________
Home # (___)______________ Work # (___)______________Cell # (___)______________ E-Mail ______________

☐Single ☐ Married ☐ Widowed ☐Separated ☐Divorced ☐Partnered for _______years ☐ Minor

Birthdate ______________ Age_________ SS# ______________ Sex ☐ M ☐ F

Patient Employer______________________________ Occupation ______________

Employer Address ______________________________

Spouse's Name ______________________________ Birthday ______________ SS# ______________

Spouse's Employer ______________________________ Work # (___)______________

DENTAL INSURANCE

Who is responsible for this account? ______________________________ Relationship to patient ______________

Insurance Company ______________________________ ID# ______________ Group # ______________

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's name ______________________________ Relationship to patient ______________

Subscriber's birthdate ______________ SS# ______________

Insurance Company ______________________________ ID# ______________ Group # ______________

ASSIGNMENT & 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.

______________________________ Date ______________
Signature of Patient, Parent, Guardian or Personal Representative

______________________________ ______________________________
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

DENTAL HISTORY

Reason for today's visit ______________________________

Former Dentist ______________

City/State ______________

Date of last dental visit ______________

Date of last dental x-rays ______________

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

Condition	Yes	No
Bad breath	☐Yes	☐No
Bleeding gums	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No
Cigarette/pipe/cigar smoking	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No
Dry mouth	☐Yes	☐No
Fingernail biting	☐Yes	☐No
Food collection between the teeth	☐Yes	☐No
Foreign object	☐Yes	☐No
Grinding teeth	☐Yes	☐No
Gums swollen or tender	☐Yes	☐No
Loose teeth or broken fillings	☐Yes	☐No
Jaw pain or tiredness	☐Yes	☐No
Lip or cheek biting	☐Yes	☐No
Mouth breathing	☐Yes	☐No
Mouth pain, brushing	☐Yes	☐No
Orthodontic treatment	☐Yes	☐No
Pain around ear	☐Yes	☐No
Periodontal treatment	☐Yes	☐No
Sensitivity to cold	☐Yes	☐No
Sensitivity to heat	☐Yes	☐No
Sensitivity to sweets	☐Yes	☐No
Sensitivity when biting	☐Yes	☐No
Sores or growths	☐Yes	☐No

How often do you floss? ______________

How often do you brush? ______________

- OVER -

DENTAL REGISTRATION & HISTORY

Health History

Are you under the care of a physician? ☐Yes ☐No If yes, for what condition? ____________________
Physician Name ____________________ Phone # ____________________ Date of last visit ____________________
Has there been any change in your general health within the past year? ☐Yes ☐No If yes, what condition ____________________
Have you had a serious illness, operation, or been hospitalized in the past 5 years? ☐Yes ☐No
If yes, what was the illness or problem? ____________________
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
Have you ever taken alendronate, (Fosomax) or risedronate (Actonel) for osteoporosis or Paget's disease? ☐Yes ☐No
Were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates (Aredia or Zometa)? ☐Yes ☐No
Do you use controlled substances (drugs)? ☐Yes ☐No
Do you drink alcoholic beverages? ☐Yes ☐No If yes, how much did you drink in the last 24 hours? __________ In a week? __________

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

Condition		Condition		Condition	
AIDS/HIV	☐Yes ☐No	Epilepsy	☐Yes ☐No	Respiratory disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting or dizziness	☐Yes ☐No	Rheumatic fever	☐Yes ☐No
Arthritis, Rheumatism	☐Yes ☐No	Glaucoma	☐Yes ☐No	Scarlet fever	☐Yes ☐No
Artificial heart valve	☐Yes ☐No	Headache	☐Yes ☐No	Shortness of breath	☐Yes ☐No
Artificial joints	☐Yes ☐No	Heart murmur	☐Yes ☐No	Sinus trouble	☐Yes ☐No
Asthma	☐Yes ☐No	Heart problems	☐Yes ☐No	Skin rash	☐Yes ☐No
Back problems	☐Yes ☐No	Hepatitis Type ________	☐Yes ☐No	Special diet	☐Yes ☐No
Bleeding abnormally, with extractions or surgery	☐Yes ☐No	Herpes	☐Yes ☐No	Stroke	☐Yes ☐No
Blood disease	☐Yes ☐No	High blood pressure	☐Yes ☐No	Swollen feet or ankles	☐Yes ☐No
Cancer	☐Yes ☐No	Jaundice	☐Yes ☐No	Swollen neck glands	☐Yes ☐No
Chemical dependency	☐Yes ☐No	Jaw pain	☐Yes ☐No	Thyroid problems	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Kidney disease	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Circulatory problems	☐Yes ☐No	Liver disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Congenital heart lesions	☐Yes ☐No	Low blood pressure	☐Yes ☐No	Tumor/growth on head/neck	☐Yes ☐No
Cortisone treatments	☐Yes ☐No	Mitral valve prolapse	☐Yes ☐No	Ulcer	☐Yes ☐No
Cough, persistent or bloody	☐Yes ☐No	Nervous problems	☐Yes ☐No	Venereal disease	☐Yes ☐No
Diabetes	☐Yes ☐No	Pacemaker	☐Yes ☐No	Weight loss, unexplained	☐Yes ☐No
Emphysema	☐Yes ☐No	Psychiatric care	☐Yes ☐No	Do you wear contact lenses?	☐Yes ☐No

Women:
Are you pregnant? ☐Yes ☐No Due date: ____________________ Are you nursing? ☐Yes ☐No Taking birth control? ☐Yes ☐No

MEDICATIONS

List any medications, vitamins, natural or herbal preparations and/or diet supplements you are currently taking and the correlating diagnosis: ____________________
____
____
____
Pharmacy Name: ____________________
Phone: (______)____________________

ALLERGIES

☐Aspirin
☐Barbituates (sleeping pills)
☐Codeine
☐Iodine
☐Latex
☐Local Anesthesia
☐Penicillin
☐Sulfa
☐Other ____________________
____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient/parent/guardian ____________________ Date ____________________

Robert D. Nunez D.D.S

200 N. La Cumbre Road, Suite M • Santa Barbara, CA 93110 • (805)682-8941

www.RobertDNunezDDS.com • RobertDNunezDDS@gmail.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name:____

Address:____

Telephone:____Email:____

Patient Number:______________________________ Social Security Number:______________________________________

Section B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A Copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in out Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which contains the changes. Those changes may apply to any of your protected health information that we maintain.

You many obtain a Copy of our Privacy Practices including any revisions of our notice, at any time by contacting:

Contact Person: Dr. Robert D Nunez or Angela Nunez (Office Manager)
Telephone: (805)682-8941 Fax: (805)898-9141
Address: 200 N. La Cumbre Rd. Suite M, Santa Barbara CA 93110

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of our revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before your revocation, and that we may decline to treat or to continue treating you if you revoke this consent.

SIGNATURE

1, ____ have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:____ Date:_______________________________

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

Personal Representative's Name:____

Relationship to Patient:____

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Dr. Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT TIME OF YOUR VISIT

For those with Dental Insurance: Treatment will be billed to insurance and a copay will be asked for at the time of the procedure. Once we receive payment from your insurance you will be billed the remainder. For major procedures we require a 50% deposit of the total cost at the time of the procedure.

For those without Dental Insurance: Payment is due at the time of treatment. For major procedures (i.e. crowns & implants) we require a 50% deposit of the total cost at the time of the procedure. The balance will be due at the time of completion unless prior arrangements are made.

We now offer the following payment options:

___ Payment by Cash

___ Payment by Check

___ Payment by Credit Card (Mastercard or Visa)

___ Payment by Care Credit

___ Automatic Monthly Billing to your Credit Card

___ Guarantee any amount not covered by insurance with Visa or MasterCard

Credit Card Provider:________________________________ Number:________________________________

Expiration:_______________________________ Zip Code:____

Please make your choice, sign below and return to office manager before treatment.

Our Office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your credit card on a monthly basis.

If none of the above applies, please see the office manager. Thank you.

Print Name:____

Signature:____ Date: ___________________

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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 April 14, 2003 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.

You may request a copy of this 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 above.

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, conduction 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, or 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 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 consent.

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 and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances we may disclose the authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions 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 must obtain a form to request access by using the contact information listed above. 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 above. For any other information you request we will charge you 20 cents for each page and 20 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 alternative format we will charge a cost-based fee for providing your health information in that format. If you prefer we will prepare a summery or an explanation of your health information for a fee. Contact us using the information listed above for a full explanation of our fee structure.

Disclosure Accounting: 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.

Restriction: 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. We are not required to agree to these additional restrictions, but if we do, we will abide by out agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request, in writing, and it must specify how or where you wish to be contacted.

Amendment: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the 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 website or by email, you are entitled to receive this notice in written form.

June 1st, 2014

Dear Valued Patient,

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice.

There is a $60.00 fee for not showing up for scheduled appointments or late cancellations. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit.

We look forward to seeing you soon!

Sincerely,

Dr. Robert Nunez and Staff