PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS **APPOINTMENT IS FOR YOU START HERE**

1

DATE

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

2

DENTAL INSURANCE

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.

3

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: | RELATIONSHIP:

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

4

ACCOUNT INFORMATION

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.

Please turn over and sign

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 (I 8% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

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 _____

Address _____ State _____ Zip _____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth? _____ How often do you floss? _____

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, pins, nails, fingernails) ❒YES ❒NO
Mouth breathe while &wake or asleep? ❒YES ❒NO
Have tired jaws, especially in the morning? ❒YES ❒NO
Smoke/chew tobacco? ❒YES ❒NO

Have you ever had:

Orthodontic treatment? ❒YES ❒NO
Oral surgery? ❒YES ❒NO
Periodontal treatment? ❒YES ❒NO
Your teeth ground or the bite adjusted? ❒YES ❒NO
A bite plate or mouth guard? ❒YES ❒NO
A serious injury to the mouth or head? ❒YES ❒NO

If so, please describe, including cause

_____

Have you experienced:

Clicking or popping of the jaw? ❒YES ❒NO
Pain? (joint, ear, side of face) ❒YES ❒NO
Difficulty in opening or closing the mouth? ❒YES ❒NO
Difficulty in chewing on either side of the mouth? ❒YES ❒NO
Headaches, neckaches or shoulder aches? ❒YES ❒NO
Sore muscles (neck, shoulders)? ❒YES ❒NO

Are you satisfied with your teeth's appearance? ❒YES ❒NO

Would you like to keep all of your teeth all of your life? ❒YES ❒NO

Do you feel nervous about having dental treatment? ❒YES ❒NO

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? ❒YES ❒NO

If yes, please describe

_____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____

_____

_____

1.800.925.2600

Patient Name

MEDICAL HISTORY

Patient Account No.

Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ❒YES ❒NO

   If yes, for what? _____

   Physician's Name _____ Phone _____

   Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? ❒YES ❒NO

3. Are you taking any medication, drugs or pills now? ❒YES ❒NO

   If yes, please list name and dosage _____

4. Have you ever taken prescription medications for weigt loss (diet pills)? ❒YES ❒NO

   If yes, did you take any of the following:
   Fen-Phen (Fenfluramine-Phentermine) ❒YES ❒NO
   Pondimem (Fenfluramine) ❒YES ❒NO
   Redux (Dexfenfluramine) ❒YES ❒NO

   If yes to any of the above, did you have a medical exam for heart issues? ❒YES ❒NO

5. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ❒YES ❒NO

   If yes, please list: _____

6. Have you been a patient in the hospital during the past five years? ❒YES ❒NO

7. Indicate which of the following you have had, or have at present. Check if using your keyboard or a pen, "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	❒YES ❒NO	Ulcers	❒YES ❒NO	Hepatitis A (infectious) B (serum)	❒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.	❒YES ❒NO
Heart Murmur	❒YES ❒NO	Glaucoma	❒YES ❒NO	H.I.V. Positive	❒YES ❒NO
High Blood Pressure	❒YES ❒NO	Contact lenses	❒YES ❒NO	Cold Sores/Fever Blisters	❒YES ❒NO
Mitral Valve Prolapse	❒YES ❒NO	Emphysema	❒YES ❒NO	Blood Transfusion	❒YES ❒NO
Artificial Heart Valve	❒YES ❒NO	Chronic Cough	❒YES ❒NO	Hemophilia	❒YES ❒NO
Heart Pacemaker	❒YES ❒NO	Tuberculosis	❒YES ❒NO	Sickle Cell Disease	❒YES ❒NO
Rheumatic Fever	❒YES ❒NO	Asthma	❒YES ❒NO	Bruise Easily	❒YES ❒NO
Arthritis/Rheumatism	❒YES ❒NO	Hay Fever	❒YES ❒NO	Liver Disease	❒YES ❒NO
Cortisone Medicine	❒YES ❒NO	Latex Sensitivity	❒YES ❒NO	Yellow Jaundice	❒YES ❒NO
Swollen Ankles	❒YES ❒NO	Allergies or Hives	❒YES ❒NO	Neurological Disorders	❒YES ❒NO
Stroke	❒YES ❒NO	Sinus Trouble	❒YES ❒NO	Epilepsy or Seizures	❒YES ❒NO
Diet (Special/ Restricted)	❒YES ❒NO	Radiation Therapy	❒YES ❒NO	Fainting or Dizzy Spells	❒YES ❒NO
Artificial Joints (hip, knee, etc.)	❒YES ❒NO	Chemotherapy.	❒YES ❒NO	Nervous/Anxious	❒YES ❒NO
Kidney Trouble	❒YES ❒NO	Tumors	❒YES ❒NO	Psychiatric/Psychological Care	❒YES ❒NO
Nickel Sensitivity	❒YES ❒NO	Bisphosphonates Therapy (Fosamax)	❒YES ❒NO		

8. Do you use more than two pillows to sleep? ❒YES ❒NO
9. Have you lost or gained more than 1 0 pounds in the past year? ❒YES ❒NO
10. Do you have or have you had any disease, condition, or problem not listed? ❒YES ❒NO

    If yes, please list: _____

11. Women. Are you: **Pregnant?** ❒YES ___ Months ❒NO Nursing? ❒YES ❒NO **Taking birth control pills?** ❒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 _____

1.800.925.2600

Dr. Massood Darvishzadeh
Walnut Creek Dental
2021 Mt. Diablo Blvd, Suite 100
Walnut Creek, CA 94596
(925) 939-3421

Missed Appointment Policy

In an effort to best accommodate all our patients, it is vitally important that all scheduled appointments are kept. These appointments have been reserved especially for you and are key to maintaining your oral health.

There will be a missed appointment fee charged if an appointment is failed, or we are not notified forty-eight hours in advance. The charge for a missed Hygiene appointment is $50.00. The charge for a missed Periodontal Therapy appointment will be $100.00. The charge for a missed appointment with Dr. Darvish is $190.00.

I have read and understand the missed appointment policy.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

[*45 CFR 164.520*]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in *plain language* that describes:

- How the covered entity may use and disclose protected health information about an individual.

- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.

- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.

- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.

- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.

- *Health Plans* must also:

  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

- *Covered Direct Treatment Providers* must also:

- Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
- When first service delivery to an individual is provided over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
- In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
- Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service

delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Notice of Privacy Practices

FAQs on ALL Privacy Rule Topics

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this Office's Notice of Privacy Practices.

Please Print Name

Signature

Date

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

Communication barriers prohibited obtaining the acknowledgment

An emergency situation prevented us from obtaining acknowledgement

(Other Please Specify)