

# REGISTRATION

## Patient Information

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

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 \_\_\_\_\_ Cell 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 Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## Dental History

Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <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 cold <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 heat <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 to sweets <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	Sensitivity when biting <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	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____

# Health History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

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<br>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<br>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 |                                    |  |
|   |  | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |

Do you wear contact lenses?  Yes  No

**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 \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES – HIPAA & 42 CFR PART 2

This Notice of Privacy Practices ("Notice") describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protected health information (PHI) includes information that identifies you and relates to your past, present, or future physical or mental health or condition, the healthcare services you receive, or payment for those services.

Some types of health information, including records related to Substance Use Disorder (SUD), receive additional protections under federal law, including regulations found at 42 CFR Part 2, in addition to HIPAA. These enhanced protections are explained later in this Notice.

### **OUR PLEDGE REGARDING YOUR HEALTH INFORMATION**

We understand that your health information is personal and confidential. We are committed to protecting the privacy and security of your protected health information (PHI). We are required by law to:

- Maintain the privacy of your PHI
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice
- Notify you if a breach occurs that may have compromised the privacy or security of your information

### **HOW WE MAY USE AND DISCLOSE YOUR PHI**

**Treatment** – We may use and disclose your PHI to provide, coordinate, or manage your dental care and related services.

**Payment** – We may use and disclose your PHI to obtain payment for services provided to you.

**Healthcare Operations** – We may use and disclose your PHI for practice operations, including quality assessment, staff training, legal compliance, auditing, and business planning.

**Appointment Reminders** – We may use or disclose your PHI to contact you about appointments, reminders, or treatment alternatives.

**Required by Law** – We may use or disclose your PHI when required by federal, state, or local law.

**Emergencies** – We may use or disclose your PHI in emergency situations as necessary to protect your health or safety.

**Public Health Activities** – We may disclose PHI for public health purposes, including disease prevention and reporting.

**Military, National Security, and Protective Services** – We may disclose PHI as required for military activities, national security, and protective services.

**Research** – We may use or disclose your PHI for research purposes when approved by law and with appropriate safeguards.

**Legal Proceedings** – We may only disclose PHI in response to a valid court order or other lawful process or by your written consent.

**Marketing** – We will not use your PHI for marketing purposes without your written authorization.

**Personal Representatives** – We may only disclose your PHI to a personal representative authorized by you in writing.

**Business Associates** – We may share your PHI with business associates who perform services on our behalf. These business associates are required by law to safeguard your information.

**Workers' Compensation** – We may disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

### **SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) RECORDS**

Some health information is considered especially sensitive and receives enhanced protection under federal law, including information related to Substance Use Disorder (SUD).

Even if this practice is not a substance use treatment provider, these protections may apply if we receive, maintain, or transmit SUD-related information as part of your health record.

#### **How SUD Information May Be Used**

SUD-related records may be used and disclosed for treatment, payment, and healthcare operations, as permitted by law, unless you request additional restrictions.

#### **Prohibition on Legal Use**

SUD-related records may not be used against you in criminal, civil, or administrative proceedings without your written consent or a specific court order.

#### **Redisclosure Limitations**

SUD-related information may not be redisclosed unless permitted by law. Additional restrictions may apply beyond standard HIPAA rules.

#### **Fundraising Restrictions**

Your SUD-related information will not be used for fundraising purposes without your consent. You have the right to opt out of fundraising communications.

### **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

You have the right to:

- **Access** – Obtain a copy of your PHI
- **Amendment** – Request corrections to your PHI
- **Accounting of Disclosures** – Receive a list of certain disclosures of your PHI
- **Restrictions** – Request limitations on how we use or disclose your PHI
- **Confidential Communications** – Request communications in a specific manner/location
- **Fundraising Opt-Out** – Opt out of fundraising communications
- **Breach Notification** – Be notified of breaches of unsecured PHI
- **Complaints** – File a complaint with the Office for Civil Rights without retaliation

### **CHANGES TO THIS NOTICE**

We reserve the right to change this Notice. Any changes will apply to all PHI we maintain. The updated Notice will be available upon request, in our office, and on our website.

**NOTICE OF PRIVACY PRACTICES  
PATIENT ACKNOWLEDGMENT**

**CONTACT INFORMATION**

If you have questions, would like additional information, or wish to exercise your rights, please contact:

Practice Name: Sonora Dentist, A Professional Corp.  
Address: 13945 Mono Way Sonora, CA 95370  
Phone Number: 209-533-9630  
Email (optional): sonoradentist@mlode.com

**PATIENT ACKNOWLEDGMENT OF NOTICE**

By signing below, you acknowledge that you have received a copy of this Notice of Privacy Practices and understand your rights under HIPAA and applicable federal confidentiality laws, including special protections related to Substance Use Disorder (SUD) information.

- I acknowledge receipt of this Notice of Privacy Practices.
- I understand that SUD-related information may have additional protections.
- I understand my right to opt out of fundraising communications.
- I understand that certain disclosures may require my written authorization.
- Their SUD-related information cannot be used for fundraising without consent.

Patient Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If the patient is unable or unwilling to sign, staff should document the reason here.

Staff Initials: \_\_\_\_\_

Date: \_\_\_\_\_

If you believe your privacy rights have been violated, you may file a complaint with us or with OCR. You will not be penalized for filing a complaint.

Practice Privacy Officer: Diane Hoeflicker  
Practice Address: 13945 Mono Way Sonora, CA 95370  
Phone Number: 209-533-9630  
Email (Optional): sonoradentist@mlode.com