PATIENT REGISTRATION AND MEDICAL HISTORY

PLEASE PRINT

Date _____

Patient Name _____ Preferred Name _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Work Phone _____ Cell _____ Email _____

M_____F_____ Birthdate _____ Age _____ SSN _____

Employed By _____ Occupation _____

Marital Status _____ Name of Spouse _____

Student Status _____ Name of School _____

Who is responsible For this account? _____ Relationship to patient _____

Employed By _____ Occupation _____

Business Address _____

Phone Number _____

Whom may we thank for referring you to this office? ❑ Location ❑ Insurance ❑ Google ❑ Patient _____ ❑ Other _____

Previous Dentist _____ Last Visit _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had the following?

Yes❑No❑ Heart Problems
Yes❑No❑ High Blood Pressure
Yes❑No❑ Low Blood Pressure
Yes❑No❑ Circulatory Problems
Yes❑No❑ Nervous Problems
Yes❑No❑ Radiation Treatment
Yes❑No❑ Artificial Heart Valves or Joints
Yes❑No❑ Recent Weight Loss
Yes❑No❑ Hepatitis, Jaundice, or Liver Disease
Yes❑No❑ Respiratory Disease
Yes❑No❑ Allergies to Medicine or Drugs

Yes❑No❑ Latex Allergy
Yes❑No❑ Epilepsy
Yes❑No❑ Head Aches
Yes❑No❑ Cancer
Yes❑No❑ Swollen Neck Glands
Yes❑No❑ Diabetes
Yes❑No❑ Psychiatric Care
Yes❑No❑ Chronic Diarrhea
Yes❑No❑ Allergies to Anesthetics
Yes❑No❑ Back Problems
Yes❑No❑ General Allergies
Yes❑No❑ Blood Disease
Yes❑No❑ Arthritis

Yes❑No❑ Bisphosphate
Yes❑No❑ Special Diet
Yes❑No❑ Heart Murmur
Yes❑No❑ Ulcer
Yes❑No❑ Stroke
Yes❑No❑ Sinus Problems
Yes❑No❑ "A.I.D.S" or HIV Positive
Yes❑No❑ Venereal Disease
Yes❑No❑ Rheumatic Fever
Yes❑No❑ Chemical Dependency
Yes❑No❑ Hemophilia
Yes❑No❑ Mitral Valve Prolapse
Yes❑No❑ Asthma

Have you ever been told by a physician that you have to Pre-Med for dental treatment? Yes❑ No❑

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so what? _____

Do you use tobacco products? Yes❑ No❑ Have you ever used tobacco products? Yes❑ No❑

Have you ever responded adversely to medical or dental treatment? _____

Are you taking medication at this time? _____ If so, what? _____

Are you under a care of a physician? Yes❑ No❑

For what condition? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? Yes❑ No❑ Are you nursing? Yes❑ No❑

Is there anything else we should know about your medical history? _____

Primary Insurance

Name of Person

Carrying Insurance_____ Relationship_____

Birthdate_____ SSN_____ Work #_____

Name of Employer_____

Name of Insurance Company_____ Group #_____

Secondary Insurance

Name of Person

Carrying Insurance_____ Relationship_____

Birthdate_____ SSN_____ Work #_____

Name of Employer_____

Name of Insurance Company_____ Group #_____

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 patients needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to 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.

It is the responsibility of the patient to understand the policies and benefits of their insurance. This incudes (1) insurance maximums, (2) covered dental benefits, (3) co-payments, (4) required referrals obtained and presented prior to services being rendered, (5) prior authorizations procedures, and (6) current claim address.

Assignment of Benefits

I hereby authorize the undersigned dentist to furnish information to insurance carriers concerning my dental condition or treatment needed. And I hereby irrevocably assign to the doctor all payments for dental services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

Patient Insured

Signature_____ Date_____

Stan M. Arellano, D.D.S. - Laguna Family Dental
9024 Franklin Blvd., Suite 100 • Elk Grove, CA 95758 • (916) 421-1400

OFFICE POLICY

Dear Patient:
We appreciate your selection of this office to serve your dental health needs. Our goal, is to provide you with the best possible dental care for our patients. We want you to enjoy optimal dental health throughout your life. This statement has been prepared to give you some information about our office policies. Please ask the front desk staff if you have any questions about any of the areas covered in this statement.

ESTIMATES:
Before we begin treatment, we will provide you with a complete diagnosis. Based on that, we will give you an estimate of the total charges for your treatment. As we proceed with this treatment, we may encounter additional problems which are not apparent to us at the time of initial examination. In that event, we will fully discuss the problem, including the effect, if any, it will have on your financial arrangements. We will not proceed without your approval.

BROKEN APPOINTMENTS:
We require 24 hours notification if you are unable to keep your scheduled appointment. If we do not receive this notice, your account will be subject to a charge based upon employee wage and overhead cost for the length of time reserved with the doctor or hygienist.

PATIENTS WITH DENTAL INSURANCE:
As a courtesy to you, we will bill your insurance company for services rendered. If we are to provide this service, you must supply us with complete information regarding your insurance and employer, including the proper insurance forms, completed and signed by the employee. We will require payment of the portion of your charges which your insurance company will not cover, including all deductibles and estimated patients portion, at the time the service is rendered. We expect payment in full after 45 days from the date of service, regardless of pending insurance claims. We will provide as much assistance as possible with insurance problems, however; the patient assumes full responsibility for resolving such matters.

PATIENTS WITH NO INSURANCE:
It is our policy to receive full payment at the time the service is rendered. For your convenience, we accept VISA and MASTERCARD. We understand that some patients have special needs. If the above is unsuitable, you must make financial arrangements with the account manager.

DELINQUENT ACCOUNTS:
Any account balance which is over 60 days old will have a finance charge of 1.5% per month added. Any account which has had no payment for 30 days is considered delinquent. If any account has had no payment for over 60 days, it may be subject to outside collection or turned over to our attorney. Small claims court action may be taken. If this account is assigned to a collection agency or an attorney, the prevailing party shall be entitled to reasonable attorney's fee and cost of collection.

I HAVE READ, UNDERSTOOD AND AGREE TO THE ABOVE:

_____ _____

Signature of Patient or Responsible Party **Date**

Laguna Family Dental Informed Consent

Patient Name _____ **Date** _____

1. TREATMENT TO BE DONE: Initials _____

I understand that I will be receiving an examination that includes a sufficient number of dental x-rays that may be necessary to complete my examination and any additional community appropriate diagnostic procedures that may be necessary to complete my dental examination and treatment plan. I also understand that if there was a need for a referral to a specialist deemed necessary by my Dentist, then the cost of this referral would be my responsibility.

2. DRUGS AND MEDICATIONS:

I understand that antibiotics, analgesics and other medication can cause allergic reactions manifesting clinical symptoms such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I understand that it is my responsibility to inform my dentist of any allergy to specific medication to avoid possible adverse effects from medication that my dentist with prescribe. Initials _____

LOCAL ANESTHETICS: The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in heart rate but will return to normal. Common complication that can occur from local anesthetic but are not limited to are pain, swelling, and bruising. Rare serious complications that may occur that can include but are not limited to permanent numbness, abnormal sensation, transient blindness, and even death. Initials _____

3. CHANGES IN TREATMENT PLAN:

I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary once I have been informed of these changes and consented to them. I also understand that by not following my dentist's recommendations, delayed treatment can lead to but not limited to more discomfort, increase the complexity of the treatment outcome, or eventual lost of teeth. Initials _____

4. EXTRACTIONS (REMOVAL OF TEETH)

I give my consent for the doctor to perform the extraction/surgery to treat and possibly correct my diseased oral tissue, or other procedures deemed necessary or advisable as necessary to complete the planned operation/extraction. If left untreated, the risk to my health may include, but are not limited to swelling, pain, infection, cyst formation, gum diseases, dental decay, malocclusion, premature loss of teeth and/or bone. My Dentist has informed me of possible alternative methods of treatment. Initials _____

Potential risks include, but are not limited to the following:

A. Post-operative discomfort; stretching of the corners of the month, with resultant cracking and bruising; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage possibly exposing crown margins; tooth looseness; delayed healing dry socket and/or infection requiring prescriptions or additional treatment, i.e. surgery.

B. Injury to adjacent teeth, prosthesis, and/ or restorations which may require additional treatment or injury to other tissues not within the described surgical areal.

C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite or tempromandibular joint jaw joint difficulty possibly requiring physical therapy or surgery.

D. Residual root fragments or bones spicules left when complete removal would require extensive surgery or needless surgical complications.

E. Possible bone, and/or jaw fracture, or opening of the maxillary sinus requiring additional surgery.

F. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue which may be temporary or permanent.

If any unforeseen condition should arise in the course of the operation/extraction, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever s)he may deem advisable, including referral to another dentist or specialist.

5. CROWNS, BRIDGES, AND CAPS:

I understand sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I may be wearing temporary crowns, which may come off easily and could be aspirated, and I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand that if my temporary crowns come off, then it is my responsibility to return to my dentist to have it re-cemented. I realize that final opportunity to make changes in my new crown, bridge, or cap including; shape, fit, size, and color will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crowns, or bridge, it may not fit properly, and I will be responsible for any lab fees. Initials _____

6. Consent For Taking Pictures

I consent of taking pictures of my dental or surgical condition. and the use of these pictures for purposes of my diagnosis or treatment.

Initial _____

7. Relationship Between Doctors and Laguna Family Dental

I am advised that all dentists and surgeons (other than Stan Arellano) that are furnishing services to me , including the oral surgeon, periodontist etc. are independent contractors and are not employees or agents of the office or of Stan Arellano DDS Inc... I understand that it is the responsibility of my dentist, surgeon, or authorized health care provider to obtain my informed consent for general or surgical procedures.

Initial _____

I have read, understood and agree to the above

_____ _____

Signature of patient or responsible party Date

NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS 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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Stan Arellano D.D.S

Laguna Family Dental

Family & Cosmetic Dentistry

9024 Franklin Blvd., Suite 100

Elk Grove, CA 95758

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY POLICY

*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____ (PRINT NAME)

Have received a copy of this office's Notice of Privacy Practices

SIGNATURE _____ **DATE** _____