Dental Registration and Health History

Patients Name_____ Social Security No._____

Birthdate_____ Age____ Sex____ Drivers License_____

Mailing Address_____

City_____ State_____ Zip_____

Home Phone _____

Cell Phone _____Email _____

Please ck (√) one: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Referred to our office by_____

Have you or any member of your family been seen by us before? ☐Yes ☐No

If yes, which family members_____

Emergency contact *other* than Spouse_____Phone ( ) _____ ____

Previous Dentist_____ City_____ Last seen_____

Employment

☐ I do not work, I am a full time student I attend: _____

Employer_____ Position_____

Employer's Address_____ City_____

Work Phone ( ) _____ Work Hours (shift) _____

Spouse or Domestic Partner

Spouse's Name_____ Social Security No._____

Birthdate_____

Employer_____ Position _____

Employer's City _____ Phone ( ) _____

Insurance

Primary Insurance_____	Second Insurance _____
Group Number _____ or Local _____	Group Number _____ or Local_____
Policy holder's name_____	Policy Holder's Name_____
Insurance Phone _____	Insurance Phone_____

Tracey Y Cook DDS, Inc.
Patient Consent to Treatment

NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT (HIPPA):

We keep a record of your personal information and the dental care we provide to you. We use this information in order to provide you with patient care. We may use your phone number, e-mail or a post card to contact you regarding your treatment or appointment. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or obtain a summary of your chart (duplication fee depends on length of summary) by contacting our office Manager.

Initial: _____

DRUGS, MEDICATIONS AND ANESTHESIA:

I understand that antibiotics, analgesics and other medications may cause adverse reactions, some of which are, but not limited to redness and swelling of tissues, pain, itching, vomiting and dizziness. I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I understand that rarely, upon injection of a local anesthetic, I may have prolonged persistent anesthesia, numbness and/or irritation to the area of the injection. I understand that if I select to utilize Nitrous Oxide the possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock and cardiac arrest. FEMALES: I understand that while on birth control pills, if I am given antibiotics, I should use an alternative way of birth control. Antibiotics suppress the effects of birth control pills.

Initial: _____

INSURANCE BENEFITS AND PAYMENTS:

If you are covered by insurance and bring the necessary information that enables us to confirm eligibility and benefits, we will be happy to bill them for your services. Upon request, an estimate will be given to me in writing, on the understanding that it is but a guideline of my treatment costs until final payment is received from your insurance company and your exact share of the bill is known. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than estimated and there is no guarantee of benefits from my insurance company to the dentist until a claim is received and processed for payment. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that the insurance company can deny payment on services rendered at any time and I will be responsible to pay the entire balance on my account. A $10.00 fee may be applied for late payments if I have a monthly statement.

Initial: _____

PAYMENT OPTIOINS

In order to keep our fees to you as low as possible, we ask that the payment be made for your rendered services at the time of treatment. For your convenience, we provide a variety of payment options to help you receive the quality of care you need to enjoy a healthy and confident smile. Please identify which form of payment is most convenient for you at the time of service.

CASH/CHECK _____ VISA/MASTERCARD _____

CHANGE IN TREATMENT PLAN:

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth. The most common being, additional tooth surfaces or additional caries discovered while working on the planned treatment. Occasionally, we may need to do root canal therapy following routine restorative procedures due to the cavity being larger and deeper than anticipated. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results.

Initial: _____

APPOINTMENTS:

We ask that you be on time for your scheduled dental appointments and if it is necessary for you to change an appointment, that you give us at least 24 hours notice so that we are able to accommodate someone else in your reserved chair time. **Our office policy is to charge $75.00 and up for missed appointments.**

Initial: _____

QUESTIONS:

Questions you may have regarding your billing or treatment need to be brought to our attention immediately. It is in our policy to provide you with exceptional service, and would like to be informed if you feel that we are not doing an adequate job.

Signature: _____ Date: _____

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 have had any of the following:

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

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Easily Winded	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Fainting Spells/Dizziness	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No
Breathing Problem	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Genital Herpes	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No	Heart Trouble/Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
									Yellow Jaundice	◯ Yes	◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

OFFICE and FINANCIAL POLICIES
Coral Bay Family Dentistry
Tracey Y. Cook, D.D.S.

Our philosophy is to provide the highest quality of patient education and dental care to all or our patients. To ensure that you begin with a positive experience we have prepared the following information for you to review. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT
In order to keep our fees to you as low as possible, we ask that payment be made at the **time of service**. For your convenience, we will provide you an estimate for services in advance of your appointment/s to ensure you opportunity to plan in advance for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the highest quality care they desire. _____ Initial

DENTAL INSURANCE
We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We ask that you familiarize yourself with your insurance benefits and provide us with the correct information for the submittal of your claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 60 days. Please remember that your insurance is a contract between you, your employer, and the insurance company; therefore, we **cannot guarantee** any **estimated** coverage. Please know that your insurance company **will not** guarantee any payment to us until the claim for payment is submitted. Not all services are covered benefits in all contracts. Therefore you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums. _____ Initial

PAYMENT OPTIONS
For your convenience, we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. Please identify which form of payment is most convenient for you at the time of service. Cash/Check____ Discover/Visa/Mastercard____ _____ Initial

PAST DUE BALANCES
All applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 60 days, or the account has been sent to collections are considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. All balances over 60 days are subject to a $10.00 rebilling fee. _____ Initial

CANCELLATION NOTICE
If you are unable to keep an appointment that has been reserved for you, we request you provide us with a 48-hour advance courtesy notice. Early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient therefore filling the time previously reserved for you. Late notice cancellations and missed appointments will be assessed a **minimum $75.00 per appointment**. We realize that emergencies do occur and we may be flexible under those circumstance _____ Initial

NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT (HIPPA):
We keep a record of your personal information and the dental care we provide to you. We use this information in order to provide you with patient care. We may use your phone number, e-mail or a post card to contact you regarding your treatment or appointment. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or obtain a summary of your chart (duplication fee depends on length of summary) by contacting our office Manager. _____ Initial

DRUGS, MEDICATIONS AND ANESTHESIA:
I understand that antibiotics, analgesics and other medications may cause adverse reactions, some of which are, but not limited to redness and swelling of tissues, pain, itching, vomiting and dizziness. I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I understand that rarely, upon injection of a local anesthetic, I may have prolonged persistent anesthesia, numbness and/or irritation to the area of the injection. I understand that if I select to utilize Nitrous Oxide the possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock and cardiac arrest. FEMALES: I understand that while on birth control pills, if I am given antibiotics, I should use an alternative way of birth control. Antibiotics suppress the effects of birth control pills.

_____ Initial

CHANGE IN TREATMENT PLAN:
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth. The most common being, additional tooth surfaces or additional caries discovered while working on the planned treatment. Occasionally, we may need to do root canal therapy following routine restorative procedures due to the cavity being larger and deeper than anticipated. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. _____ Initial

INFORMATION CHANGES
To ensure your records are current, please notify us of any changes related to your medical history, telephone number(s), address, employer or insurance information as they occur. _____ Initial

My signature indicates that I understand the policies as outlined and any questions I have with regard to office policies have been answered.

_____ _____

Signature of Responsible Party or Patient Date

(Effective: 10-06-2015)

HIPAA PRIVACY FORM 1

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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 1-1-14, 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 the 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 our 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 at the end of this Notice.

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, 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 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, 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 will not use your health information for marketing communications without your written authorization.

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 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 institution 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 may obtain a form to request access by using the contact information listed at the end of this Notice. 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 at the end of this Notice. If you request copies, we will charge you $0.15 for each page, $10.00 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 an alternative 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 using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 an emergency).

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 how payments will be handled under the alternative means or location you request.

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 circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

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

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 complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Karlos Hernandez- Office Manager

Telephone: (530) 753-2845 Fax: (530) 753-1397

E-mail: admin.tcookdds@sbcglobal.net

Address: 227 C Street Davis, CA 95616
