



164 W. Hospitality Lane, Suite #127  
San Bernardino, CA 92408  
(909) 453-6600

## PATIENT REGISTRATION

PATIENT LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ SSN#: \_\_\_\_\_

How do you wish to be addressed? \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (Mobile) \_\_\_\_\_ (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

Email \_\_\_\_\_

How did you hear about Cal Select Dental Group? \_\_\_\_\_

### DENTI-CAL INSURANCE INFORMATION

**Please present your Denti-Cal Beneficiary Insurance Card (BIC) to our staff to be photocopied for our records.**

### RESPONSIBLE PARTY *(If minor under age of 18)*

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Initial: \_\_\_\_\_

Address *(If different)* \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Email \_\_\_\_\_

### EMERGENCY CONTACT

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Initial: \_\_\_\_\_

Telephone (Mobile) \_\_\_\_\_ (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

### AUTHORIZATION

I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice, and treatment to another dentist, or for evaluating and administering any claims for Denti-Cal benefits. I consent to the direct payment of my Denti-Cal benefits to dentist or dental group. I consent to receiving HIPAA-compliant electronic communications, such as email and/or text messages regarding treatment, payment and health care operations. I understand that there is no obligation to receive these electronic communications. Message/data rates may apply, and I may opt-out of receiving electronic communications at any time by clicking the unsubscribe link provided in emails, or by replying STOP via text.

I attest to the accuracy of the information on this page.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(Responsible Party, if under 18)*

## DENTAL & MEDICAL HEALTH HISTORY FORM

PATIENT LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

### DENTAL HISTORY

Reason for Today's Visit \_\_\_\_\_ Date of Last Dental Visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of Last Dental X-rays \_\_\_\_\_

**Please check if you have/had:**

	Yes	No		Yes	No	
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Head, neck, jaw pain, or aches	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an allergic reaction to Lidocaine, Septocaine, or any general anesthetics? Yes <input type="checkbox"/> No <input type="checkbox"/>
Blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>	
Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please explain _____
Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cigarette, pipe, or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>	
Food collection between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to pressure or irritants	<input type="checkbox"/>	<input type="checkbox"/>	
Clench or grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	(cold, heat, sweets)			
Growths or sore spots in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____			
Gums swollen, tender or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____			

### MEDICAL HISTORY

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

Physician's address \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Have you had any serious illnesses or operations: Yes  No  - If yes, please describe \_\_\_\_\_

Have you ever had a blood transfusion: Yes  No  - If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant? Yes  No  - If yes due date \_\_\_\_\_ Nursing? Yes  No  Taking birth control pills? Yes  No

**Please CIRCLE if you have/had ANY of the following:**

Allergies, hay fever, sinusitis	Headaches	Slow healing wounds
Anemia	Heart murmur	Stroke
Arthritis, Rheumatism	Heart problems	Swelling of feet or ankles
Artificial heart valves	Hepatitis – Type: _____	Thyroid problems
Artificial joints	Herpes	Tonsillitis
Asthma	High blood pressure	Tuberculosis
Required Hospitalization? _____	Any immune deficiency	Tumor or growth on head/neck
Have you used steroids _____	Jaundice	Ulcer
Date of last episode _____	Kidney disease	Venereal disease
Bleeding abnormally with operations or surgery	Low blood pressure	Weight loss, unexplained
Blood disease, clotting disorders	Mitral valve prolapse	<b><u>ALLERGY ALERTS</u></b>
Cancer	Osteoporosis	Are you allergic/sensitive to Latex? _____
Chemical dependency	Osteopenia	Allergic to Penicillin, Aspirin, or other drugs? _____
Chemotherapy	Pacemaker	<i>If Yes, please specify</i> _____
Circulatory problems	Radiation treatments	_____
Cortisone treatments	Respiratory disease	_____
Cough, persistent or bloody	Rheumatic fever	_____
Diabetes	Scarlet fever	_____
Emphysema	Shortness of breath	List any medications that you are taking:
Epilepsy	Sinus trouble	_____
Fainting	Sickle cell anemia	_____

### AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_



## PRIVACY PRACTICES RECEIPT / CONSENT FORM

### NOTICE OF PRIVACY PRACTICES

**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 the 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 our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Compliance Officer:** Mario Melara, CEO  
**Telephone:** (909) 453-6600  
**Address:** 164 W. Hospitality Lane, Suite #127 San Bernardino, CA 92408

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your 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 we received your revocation.

### PATIENT/RESPONSIBLE PARTY SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and the 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 dental care operations.

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

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

### 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 acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

### Your Information. Your Rights. Our Responsibilities.

This notice describes how dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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#### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

#### Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Provide you with appointment reminders (such as voicemail messages, texts, postcards, or letters).

#### Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

##### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

##### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing in 60 days.

#### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

#### Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or dental care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your dental insurance. We will say "yes" unless a law requires us to share that information.

#### Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

## **Tell us what you want us to do, and we will follow your instructions.**

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

## **Our Uses and Disclosures**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

### **Treat you**

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

### **Bill for your services**

We can use and share your health information to bill and get payment from dental plans or other entities.

Example: We give information about you to your dental insurance plan so it will pay for your services.

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

## **Do research**

We can use or share your information for health research.

## **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

## **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

## **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

## **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

## **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

## **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.



## CONSENT/RESTRICTION TO SHARE INFORMATION

### CONSENT TO SHARE INFORMATION

I **CONSENT** to share information regarding dental treatment, personal health information, dental benefit information, and all matters regarding the account, to the following individual(s).

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature (*Legal Guardian, if Patient is a minor*)

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

### RESTRICTION OF PATIENT INFORMATION

I **DO NOT CONSENT** to share information regarding dental treatment, personal health information, dental benefit information, and all matters regarding the account, to the following individual(s):

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature (*Legal Guardian, if Patient is a minor*)

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



## Provider & Patient Pledge

### Our Pledge

- Treat you with respect, honesty, and compassion
- Hold ourselves to the highest dental quality and safety standards
- Help you set goals to achieve a healthy and beautiful smile
- Provide information to you in an understandable way
- Communicate openly about your benefits and help you make an informed decision about your dental care and treatment options

*Cal Select Dental Group*

### Your Pledge

- Be a responsible patient and ensure I maintain all my dental appointments
- Treat office staff with respect, honesty, and consideration
- Understand my dental conditions, benefits, and make decisions that is best for my long-term oral health
- Ask questions when I do not understand and until I do understand
- Appreciate and value Cal Select Dental's state-of-art dental facility that has been provided for me
- If I am not happy I will tell you and if I am happy I will tell others

X \_\_\_\_\_  
Patient/ Responsible Party Signature

\_\_\_\_\_  
Date