Patient Registration

Email: Today's Date:

1. ABOUT OUR HOSPITALITY DENTAL PATIENT

Name _____ Birthdate _____ ☐ Male ☐ Female
(First) (M.I.) (Last)

Nickname or name preference _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Residence Address _____ Age _____
(street) (city) (ST) (zip)

Mailing Address (if different from above) _____

Primary Phone #: (_____)_____ ☐Cell Second Phone #: (_____)_____ ☐Cell

Work Phone #: (_____)_____ Ext. _____

What is the best time of day to call? 7am-9am 9am-12pm 12pm-5pm 5pm-8pm Anytime Social Security #:_____-_____-_____

Driver's License #: _____ E-MAIL ADDRESS:_____

Employer _____

Employer Address _____

Is the Patient a Dependent? ☐ Yes ☐ No (if yes, please fill out section 2) Is the patient a full-time student? ☐ Yes ☐ No

Who may we thank for referring you to our office?_____ Name of school:_____

LIST OTHER IMMEDIATE FAMILY MEMBERS NOT SEEN BY US YET: 1. _____ Age_____

2. _____ Age_____ 3. _____ Age_____

Do you have any of the following symptoms?	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

2. SPOUSE/RESPONSIBLE PARTY

Their Name _____ Relation _____

Billing Address _____

Employer _____

Employer Address _____

Primary Phone #: _____ Best time to call: AM

Second Phone #:_____ Birthdate: _____

SS#:_____-_____-_____ DL#:_____

3. EMERGENCY CONTACT

In the event of an emergency, we may need to contact a relative or someone who lives near you other than immediate family.

Their Name _____

Address _____

Relationship to Patient _____

Day Phone (_____)_____

Evening Phone (_____)_____

3. DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insured's Name _____ Relation _____

SS#:_____ Birthdate _____

Insured's Employer _____

Employer Address _____

Insurance Co. Name _____

Group # (Plan,Local or Policy #) _____

SECONDARY DENTAL INSURANCE

Insured's Name _____ Relation _____

SS#:_____ Birthdate _____

Insured's Employer _____

Employer Address _____

Insurance Co. Name _____

Group # (Plan,Local or Policy #) _____

4. 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 dental benefits. I consent to the direct payment of my dental benefits to Hospitality 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. I acknowledge receipt of the Dental Materials fact sheet and Notice of Privacy Practices.

Signature_____ Date _____
(Responsible Party, if under 18)

Patient Name: _____ **ACCT: #**_____

5. DENTAL HISTORY

Reason for dental visit/concern? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor
Approximate date of your last dental visit:_____
How many times a week do you floss? _____
How many times a day do you brush? _____
Type of bristles used: ☐ Hard ☐ Medium ☐ Soft ☐ N/A

Any apprehension or unfavorable experience in a dental office?	Yes No	Have you ever experienced TMJ problems?	Yes No
Would you like to prevent the need for dentures?	Yes No	(TMJ is pain or discomfort in your jaw joint?	Yes No
Do your gums ever bleed?	Yes No	Are you under any unusual stress at home or work?	Yes No
Do you like your smile?	Yes No	Do you grind your teeth?	Yes No

6. MEDICAL HISTORY

Age: _____ **Height:** _____ **Weight:** _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor *(Circle One)*

Are you currently under the care of a physician?	Yes No	If Yes, Please Explain: _____
Any serious medical problems in the last 5 years?	Yes No	If Yes, Please Explain: _____
Are you taking prescription(s) / over the counter drugs?	Yes No	If Yes, Please Explain: _____

Are you taking ANY of the following:

Antibiotics or sulfa drugs?	Yes No
Do you take pre-medication before dental treatment?	Yes No
Anticoagulants (blood thinners)?	Yes No
Aspirin?	Yes No
Cortizone (steroids)?	Yes No
Digitalis or drugs for heart trouble?	Yes No
High blood pressure medication?	Yes No
Insulin, Tolbutamide (Orinase) or similar drug?	Yes No
"OSTEOPOROSIS DRUG" now or within in the last 5 years: Aclonel, Boniva, Oidronel, Aredia, Fosamax, Skelid, Bonefos, Zometa, etc.?	Yes No
Tranquilizers?	Yes No
Other:_____	Yes No

Have you had, experienced, or currently have any of the following:

Asthma. allergies or hay fever?	Yes No
Arthritis?	Yes No
Fainting spells or seizures?	Yes No
Hepatitis, jaundice or liver disease?	Yes No
HIV or AIDS?	Yes No
Hives or skin rash?	Yes No
Inflammatory Rheumatism (painful, swollen joints)?	Yes No
Kidney trouble?	Yes No
Rheumatic fever or rheumatic heart disease?	Yes No
Stomach ulcers?	Yes No
Tuberculosis?	Yes No
Venereal Disease?	Yes No

Are you ALLERGIC or have you REACTED ADVERSELY to:

Aspirin?	Yes No
Barbiturates, sedatives or sleeping pills?	Yes No
Iodine?	Yes No
Latex?	Yes No
Local Anesthetics?	Yes No
Penicillin or other antibiotics?	Yes No
Sulla drugs?	Yes No
Other: _____	Yes No

Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No

Do you bruise easily?	Yes No
Have you ever required a blood transfusion?	Yes No
Do you have a persistent cough or cough up blood?	Yes No

Do you have any blood disorders such a s anemia?	Yes No
Have you had surgery or x-ray treatment for a tumor/cancer, growth or other condition of your mouth or lips?	Yes No
Do you have any implants and/or prosthesis (i.e. knee joints, elbow joints,hip joints)?	Yes No
Do you drink alcoholic beverages frequently?	Yes No
Do you smoke?	Yes No
Do you vape?	Yes No
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease?	Yes No
Have you ever taken Fen-Phen	Yes No

Have you been EXPOSED to, or HAD any of the following:

Cardiovascular Disease (heart trouble or heart attack, high or low blood pressure, coronary insufficiency or coronary occlusion, arteriosclerosis or stroke?	Yes No
○ Do you have pain in your chest upon exertion?	Yes No
○ Are you ever short of breath after mild exercise?	Yes No
○ Do your ankles swell?	Yes No
○ Mitral valve prolapse?	Yes No
○ Heart murmur?	Yes No
○ Congenital Heart Lesions?	Yes No
○ Artificial (prosthetic) heart valve?	Yes No
○ Damaged valves?	Yes No
○ Congenital heart disease (CHD)?	Yes No
Diabetes?	Yes No
○ Do you have to urinate (pass water) more than six (6) times a day?	Yes No
○ Are you thirsty much of the time?	Yes No
○ Does your mouth frequently become dry?	Yes No

For Women:

Are you taking birth control pills?	Yes No
Are you possibly pregnant?	Yes No
If yes, week # _____	

7. ACKNOWLEDGEMENT

I understand that any information I have provided, including but not limited to my personal information, my medical and dental history, is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my personal information, medical status, and/or dental insurance.

X _____***(Signature (Patient/Responsible Party)*** Date:_____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with patient named herein. **DOCTOR SIGNATURE:** _____
Doctor Comments: _____
Medical History Update: Comments:
Date _____ Initials _____ Date _____ Initials _____ Date _____ Initials _____

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:	**Traci Whiting, Director of Operations**
Telephone:	**(909) 888-7817**
Address:	**164 W. Hospitality Lane, Suite #1A 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.

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.

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:

HOSPITALITY
Dental & Orthodontics
Trusted Since 1971

PHOTO RELEASE FORM

Patient Name: _____

Instagram/Facebook:_____

I hereby grant the Hospitality Dental & Orthodontics permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of the Hospitality Dental & Orthodontics and will not be returned.

I hereby irrevocably authorize the Hospitality Dental & Orthodontics to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge the Hospitality Dental & Orthodontics from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

_____	_____	_____
Print Name	Signature	Date

If under 18, Legal Guardian must sign.

_____	_____	_____
Legal Guardian/Print Name	Signature	Date