10683 Magnolia Ave, Suite D, Riverside CA 92505
(951)710-3925

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)

CAL SELECT
DENTAL GROUP

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	☐	☐	Head, neck, jaw pain, or aches	☐	☐
Blisters on lips or mouth	☐	☐	Lip or cheek biting	☐	☐
Burning sensation on tongue	☐	☐	Loose teeth or broken fillings	☐	☐
Chew on one side of mouth	☐	☐	Mouth breathing issues	☐	☐
Cigarette, pipe, or cigar smoking	☐	☐	Orthodontic treatment	☐	☐
Smokeless tobacco	☐	☐	Nitrous Oxide	☐	☐
Dry mouth	☐	☐	Periodontal treatment	☐	☐
Food collection between teeth	☐	☐	Sensitivity to pressure or irritants	☐	☐
Clench or grind teeth	☐	☐	(cold, heat, sweets)		
Growths or sore spots in your mouth	☐	☐	How often do you floss? ______________		
Gums swollen, tender or bleeding	☐	☐	How often do you brush? ______________		

Have you ever had an allergic reaction to Lidocaine, Septocaine, or any general anesthetics? Yes ☐ No ☐

If Yes, please explain ______________________________

____

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
Anemia
Arthritis, Rheumatism
Artificial heart valves
Artificial joints
Asthma
- Required Hospitalization? ______________
- Have you used steroids ______________
- Date of last episode______________

Bleeding abnormally with operations or surgery
Blood disease, clotting disorders
Cancer
Chemical dependency
Chemotherapy
Circulatory problems
Cortisone treatments
Cough, persistent or bloody
Diabetes
Emphysema
Epilepsy
Fainting

Headaches
Heart murmur
Heart problems
Hepatitis – Type:__________
Herpes
High blood pressure
Any immune deficiency
Jaundice
Kidney disease
Low blood pressure
Mitral valve prolapse
Osteoporosis
Osteopenia
Pacemaker
Radiation treatments
Respiratory disease
Rheumatic fever
Scarlet fever
Shortness of breath
Sinus trouble
Sickle cell anemia

Slow healing wounds
Stroke
Swelling of feet or ankles
Thyroid problems
Tonsilitis
Tuberculosis
Tumor or growth on head/neck
Ulcer
Venereal disease
Weight loss, unexplained

ALLERGY ALERTS

Are you allergic/sensitive to Latex? ______________

Allergic to Penicillin, Aspirin, or other drugs? ______________

If Yes, please specify ______________________________

____

____

____

____

List any medications that you are taking:

____

____

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:	**Mayra Torres, Director of Operations**
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.

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:

PHOTO RELEASE FORM

Patient Name: ____

Instagram/Facebook:______________________________________

I hereby grant Cal Select Dental Group 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 Cal Select Dental Group and will not be returned.

I hereby irrevocably authorize Cal Select Dental Group 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 Cal Select Dental Group 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

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