HOSPITALITY
Dental & Orthodontics
Trusted Since 1971

ACCOUNT #:_____

TODAYS DATE: _____

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 Hospitality Dental & Orthodontics? _____

IMMEDIATE FAMILY MEMBERS *(Not seen by us yet)*

1. _____ Age: _____ 2. _____ Age: _____

3. _____ Age: _____ 4. _____ Age: _____

INSURANCE & EMPLOYER INFORMATION

Insurance Name: _____ Group # or ID #: _____

Employer Name: _____

Employer Address: _____

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

Last Name:_____ First:_____ SSN#:_____

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 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)

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ACCOUNT #:_____

TODAYS DATE: _____

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, Cigar or Vaping	☐	☐	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	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	Tonsilitis
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	**ALLERGY ALERTS**
Cancer	Osteoporosis	Are you allergic/sensitive to Latex? _____
Chemical dependency	Osteopenia	Allergic to Penicillin, Aspirin, or other drugs? _____
Chemotherapy	Pacemaker	*If Yes, please specify* _____
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 medical history questions to the best of my knowledge.

Patient/Guardian Signature_____ Date_____

Dentist Signature (Reviewed): _____ Date _____

Date _____ Initials _____ Date _____ Initials _____ Date _____ Initials _____

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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) 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)_____

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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: