TIME: _____ DATE: _____

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

RESPONSIBLE PARTY (if other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Adress: City, _____ Address 2: _____

State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Security: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

PATIENT INFO:

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Gender: ☐ Male ☐ Female ☐ Unknown Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

PATIENT INFO 2:

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

PATIENT INFO 3:

_____

Referred By Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

PRIMARY INSURANCE INFO

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

SECONDARY INSURANCE INFO

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Carmel Mountain Dental Office

MEDICAL FORM

Patient Name: _____ Birth Date: _____ Date Created: _____

Are you under a physician's care now?	Yes ◯ No ◯	If yes
Have you ever been hospitalized or had a major operation?	Yes ◯ No ◯	If yes
Have you ever had a serious head or neck injury?	Yes ◯ No ◯	If yes
Are you taking any medications, pills, or drugs?	Yes ◯ No ◯	If yes
Do you take or have you taken Phen-Fen or Redux?	Yes ◯ No ◯	If yes
Have you ever taken Fosamax, Bonva, Actonel or any other medications containing bisphosphonates	Yes ◯ No ◯	If yes
Do you use tobacco?	Yes ◯ No ◯	

DENTAL INFORMATION

For the following questions, please mark your responses (x)

Do your gums bleed?	Yes ◯ No ◯	Are your teeth sensitive?	Yes ◯ No ◯
Is your mouth dry?	Yes ◯ No ◯	Have you had braces?	Yes ◯ No ◯
Do you have jaw pain?	Yes ◯ No ◯	Do you brux or grind your teeth?	Yes ◯ No ◯

Are you allergic to any of the following?

◯ Aspirin	◯ Penicillin	◯ Codeine	◯ Acrylic
◯ Metal	◯ Latex	◯ Sulfa Drugs	◯ Local Anesthetics

Other? ◯ If yes

Women: Are you...

◯ Pregnant/trying to get pregnant? ◯ Nursing? ◯ Taking oral contraceptives?

Do you use controlled substances? ◯ Yes ◯ No If yes

Do you have/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 Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Sweling 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	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 If yes

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 responsibilty to inform the dental office of any chances in medical status.

Signature of Patient, Parent, or Guardian:

Date: _____

CARMEL MOUNTAIN DENTAL OFFICE POLICY AND AGREEMENT

1. Fee for Service: If you do not have dental insurance, dental services provided are charged directly to the patient or the guardian of a minor patient. The responsible party for a minor is the person who signs this form and/or brings the minor to scheduled appointments. Payments for services rendered are due at the time of service.

2. Assignments of Insurance: The insured patient authorizes the insurance company to pay directly to this office any benefits from the insured's policy. It is agreed to have the insured's signature considered to be 'on file' in Boxes 36 and 37 of the Standard ADA Insurance Form.

3. Patient Portion: When there is expected dental insurance coverage, the estimated portion of the claim is due and payable at the time of service unless other arrangements are made.

4. Insurance Denial: In the event of non-payment or denial of coverage, the patient or the responsible party agrees to pay for services rendered. Payment is due within ten days of notification.

5**. Non-payment by Insurance:** If the insurance company has not made payment within 45 days, the balance is due and payable by the patient or responsible party. Our office will not enter into disputes over claims but will assist in clarifying your claim.

6. Benefit and Fee Quotes: Benefits quoted by our office are not a guarantee or reimbursement. Final determination of benefits is made only when a claim is processed by your insurance provider.

7. Contact Permission: Permission is granted to the doctor, staff or their assigns to telephone the patient or responsible party at home, work, or cell to discuss treatment, insurance, or account matters.

8. Non-covered Treatment: This office may charge up to the usual and customary (UCR) fee for non-covered services under State and Federal law. A written treatment plan will be provided. The dentist is not prohibited from providing services not covered by insurance.

9. Missed or Cancelled Appointments: A 24-hour cancellation notice is required. Failure to give notice will result in a $50 charge per appointment plus $25 for each additional hour scheduled.

10. Declining of a Service: This office reserves the right to decline services to any patient for cause. Failure to keep appointments or make payment is sufficient cause.

11. Returned Checks: A minimum charge of $25 will be billed for each returned check.

12. Consent for Treatment: Permission is given to Dr. Stephanie Nguyen to administer anesthetics and perform necessary services as deemed advisable in the diagnosis and treatment of the patient. The doctor has explained significant risks, benefits, and alternatives to treatment.

Signature of Patient: _____ Date:_____

Signature of Patient/Guardian (If patient is a minor): _____ Date:_____

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below, also read and sign the section at the bottom of the form.

Patient Name _____

Exam _____ Xrays _____ Fluoride _____ Sealants _____ Prophy _____ Fillings _____

1. Drugs and Medications

I understand the antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction), accelerated heart rate, prolonged numbness, tingling, and/or injury to nerves. (initials_____)

2. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures due to conditions found while working on teeth that were not discovered during examination. The most common being root canal therapy following routine procedures. I give permission to the dentist to make any/all changes and additions as necessary. (initials _____)

3. Removal of Teeth

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth _____ and any other necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have any further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spreading of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractures of jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. (initials _____)

4. Crown, Bridges and Cap

I understand that sometimes it is not possible to match the color of my teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap will be before cementation.
(initials _____)

6. Dentures, Complete or Partial

I understand that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. (initials _____)

7. Endodontic Treatment (Root Canal)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extended through the root, which does not necessarily affect the success of treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
(initials _____)

8. Periodontal Loss (Tissue and Bone Loss)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. (initials _____)

I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is minor _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

CARMEL MOUNTAIN DENTAL OFFICE
14391 Penasquitos Drive, Ste A, San Diego, CA 92129

I, _____, hereby acknowledge that I have received and reviewed a copy of Carmel Mountain Dental Office's HIPAA Notice of Privacy Practices.

I understand that Carmel Mountain Dental Office's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Carmel Mountain Dental Office's revised HIPAA Notice of Privacy Practices upon request.

I understand that, if I have questions about Carmel Mountain Dental Office's HIPAA Notice of Privacy Practices, I may contact Dr. Stephanie Nguyen at 858-672-0400.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Carmel Mountain Dental Office will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Carmel Mountain Dental Office's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Dr. Stephanie Nguyen, noted above, for assistance.

Patient Signature: _____ Date: _____

Signature of Parent/Guardian (if patient is a minor): _____ Date: _____

Relationship of Personal Representative to Patient: _____

Additionally, If you would like to authorize the disclosure of your dental treatment information and records to a family member or personal representative, please provide their name and relationship below.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

FOR OFFICE USE ONLY

Carmel Mountain Dental Office made a good-faith effort to obtain Acknowledgement from the patient noted above, of receipt of its HIPAA Notice of Privacy Practices. In spite of these efforts, Carmel Mountain Dental Office was unable to obtain a signed Acknowledgement for the following reason(s):

- □ Refusal to sign Acknowledgement on _____, 20___.
- □ Communication barriers prohibited us from obtaining a signed Acknowledgement.
- □ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- □ Other (Describe): _____

Date Received: _____ By: _____ Patient ID: _____