DENTAL REGISTRATION AND HISTORY

Date ___/ ___/_____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____

Last Name First Name MI

Address _____ Email _____

City _____ State_____ Zip_____

❑ M ❑ F Age_____ Birthdate___/___ /_____ ❑ Married ❑ Widowed ❑Single ❑ Minor

❑ Separated ❑ Divorced ❑ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Who referred you to our office? _____

Emergency Contact _____ Phone (____) _____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental care ___/___/_____

Former dentist _____ Date of last dental X-rays ___/___/_____

Address _____

Check ( ) if you have had problems with any of the following:

❑ Bad breath
❑ Bleeding gums
❑ Clicking or popping jaw
❑ Food collection between teeth
❑ Grinding teeth
❑ Loose teeth or broken fillings
❑ Periodontal treatment
❑ Sensitivity to cold
❑ Sensitivity to hot
❑ Sensitivity to sweets
❑ Sensitivity when biting
❑ Sores or growths in the mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit___/___/_____
Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).
❑ Y ❑ N

Have you had any serious illnesses or operations? ❑ Y ❑ N
If yes, describe _____
Have you ever had a blood transfusion? ❑ Y ❑ N
If yes, give approximate date(s) _____
(Women)
Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check ( ) if you have or have had any of the following:

❑ Anemia	❑ Cortisone Treatments	❑ Hepatitis	❑ Scarlet Fever
❑ Arthritis, Rheumatism	❑ Cough, Persistent	❑ High Blood Pressure	❑ Shortness of Breath
❑ Artificial Heart Valves	❑ Cough Up Blood	❑ HIV/AIDS	❑ Skin Rash
❑ Artificial Joints	❑ Diabetes	❑ Jaw Pain	❑ Stroke
❑ Asthma	❑ Epilepsy	❑ Kidney Disease	❑ Swelling of Feet or Ankles
❑ Back Problems	❑ Fainting	❑ Liver Disease	❑ Thyroid Problems
❑ Blood Disease	❑ Glaucoma	❑ Mitral Valve Prolapse	❑ Tobacco Habit
❑ Cancer	❑ Headaches	❑ Pacemaker	❑ Tonsillitis
❑ Chemical Dependency	❑ Heart Murmur	❑ Radiation Treatment	❑ Tuberculosis
❑ Chemotherapy	❑ Heart Problems	❑ Respiratory Disease	❑ Ulcer
❑ Circulatory Problems	❑ Hemophilia	❑ Rheumatic Fever	❑ Venereal Disease

MEDICATIONS:
List any medications you are currently taking:
_____
Pharmacy Name _____
Phone (___) _____

ALLERGIES:

❑ Aspirin	❑ Sulfa
❑ Barbiturates (Sleeping Pills)	❑ Latex _____
❑ Codeine	❑ Other _____
❑ Local Anesthetic	_____
❑ Penicillin	

SIGNATURE:
The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ___/___/_____ Signature _____

Gateway Oaks Dental Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Gateway Oaks Dental, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you. You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 515F, Washington, DC 20201), by email (OCRComplaint@hhs.gov) or online (www.hhs.goviocr/privacythipaa/complaints). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Dr. Hoang Truong at (916) 649-0249 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of the (Practice Name) Notice of Privacy Practices. Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____