PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1

DATE			
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
PHONE		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

SECONDARY CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

3

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: RELATIONSHIP:

YOU WERE REFERRED TO US BY

YOUR FORMER ADDRESS

CITY STATE ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY STATE ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY STATE ZIP

4

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME	
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.
ADDRESS	
CITY STATE ZIP	
PHONE NO.	

YOU

NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.

YOUR SPOUSE

NAME	
OCCUPATION	
EMPLOYER'S NAME	
ADDRESS	CITY
PHONE NO.	FAX NO.

FORM 001-0301

Please turn over and sign

PATIENT'S NAME _____ _____ _____
Last First Initial

CIRCLE THE APPROPRIATE ANSWER

1. Physician's Name _____
   Address _____
   _____
2. Are you under a physician's care? ..... YES NO
   Since when? _____ Why? _____
3. When was your last complete physical exam? _____
4. Are you taking any medication? ..... YES NO
   If yes, please list medications: _____
5. Do you routinely take aspirin or other non-prescription medicines? ..... YES NO
   If yes, please list: _____
6. Are you allergic to any medications? ..... YES NO
   If yes, please list: _____
7. Do you have any other allergies? _____
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ... YES NO
9. Are you sensitive to any metals or latex? ..... YES NO
10. Are you pregnant or suspect you may be? ..... YES NO
11. Do you use any birth control medications? ..... YES NO
12. Have you ever been treated for or been told you might have a heart disease? ..... YES NO
13. Do you have a pacemaker or an artificial heart valve implant? ..... YES NO
14. Have you ever had rheumatic fever? ..... YES NO
15. Are you aware of any heart murmurs? ..... YES NO
16. Do you have high or low blood pressure? ..... YES NO
17. Have you ever had a serious illness or major surgery? ..... YES NO
    If yes, explain _____
18. Have you ever had radiation treatment, chemo treatment for a tumor, growth or other condition? YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? ..... YES NO
20. Do you have any artificial joints / prosthesis? ..... YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc? ..... YES NO
22. Have you ever bled excessively after being cut or injured? ..... YES NO
23. Do you have any stomach problems? ..... YES NO
24. Do you have any kidney problems? ..... YES NO
25. Do you have any liver problems? ..... YES NO
26. Are you diabetic? ..... YES NO
27. Do you have asthma? ..... YES NO
28. Do you have epilepsy or seizure disorders? ..... YES NO
29. Do you or have you had venereal disease? ..... YES NO
30. Have you tested HIV positive? ..... YES NO
31. Do you have AIDS? ..... YES NO
32. Have you had or do you test positive for hepatitis? ..... YES NO
33. Do you or have you had T.B.? ..... YES NO
34. Do you smoke, chew, use snuff or any other forms of tobacco? ..... YES NO
35. Do you consume alcoholic beverages? ..... YES NO
36. Do you habitually use controlled substances? ..... YES NO
37. Have you had psychiatric treatment? ..... YES NO
38. Do you have any disease, condition, or problem not listed? ..... YES NO
    If yes, explain: _____
39. Is there anything else we should know about your health that we have not covered in this form?
    _____
40. Would you like to speak to the Doctor privately about any problem? ..... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MEDICAL HISTORY

MED. ALERT

Casas DENTAL CARE

Office Cancellation/NO Show Policy

We understand that situations may arise and you must cancel you appointment. We request that if you ***must*** cancel your appointment you provide us with at least a 24 hour notice.

This will enable for another patient who is waiting for an appointment to fill that slot. With cancellations made less than 24 hour notice, we are unable to offer that slot to other patients.

Cancelled appointment without 24 hour notice may be subject to a **$50** cancellation fee.

Patients who do not show up for their appointment without a call to cancel will be considered a **NO SHOW**. Patient who No-Show to scheduled appointment may also be subject to a **$50** NO Show fee.

Cancellation /No show fees will be sole responsibility of the patient, and must be paid in full prior to patient's next appointment.

We understand that special *unavoidable* circumstances may cause cancellation within 24 hours in these cases fees may be waived only by management approval.

Thank you for your cooperation.

Patient Signature:_____Date:_____

Casas DENTAL CARE

Consent for Dental Treatment

Please read this form carefully! If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it to you!

1. I request and authorize the treatment and procedures for my child.
2. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).
3. I have had the treatment explained to me by Dr. Gilda I. Casas or her assistants and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment at all.
4. The usual and most frequent risks or complications occurring from the planned treatment and procedures have also been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness and allergic reactions.
5. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's plan of care and that I will be consulted during or the end treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives.
6. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age.
7. I understand that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements.
8. For the purpose of advancing medical-dental education, I give permission for the use of clinical dental photographs of the patient for diagnostic, scientific, educational or research purposes.
9. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient.
10. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
11. I confirm that I have read and understand this form or it was read/explained to me.

Please remember, only estimates are given and we cannot guarantee coverage. Anything that is not covered will be your responsibility!

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies. If you prefer, we will prepare a summary or an explanation of your health information.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Casas DENTAL CARE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new term of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Acknowledgement of Receipt of Notice of Privacy Practices

This form acknowledges that you have been provided with a copy of our office's Notice of Privacy Practices.

Please print your name

Your Signature

Date

For Office Use Only

We attempted to obtain an Acknowledgement of receipt of our office's Notice of Privacy Practices, but such Acknowledgement could not be obtained because:

- ☐ Patient refused to sign
- ☐ Communication barriers prohibited obtaining the Acknowledgement
- ☐ An emergency situation prevented us from obtaining the Acknowledgement
- ☐ Other (Please Specify) _____