PATIENT REGISTRATION

First Name: ______________________________ **Last Name:** _________________________ **Middle Initial:** ___

Preferred Name: ______________________________________

Responsible Party (if someone other than the patient)

First Name: ____________________________ Last Name: __________________________________ Middle Initial: ________

Address: ____

City, State, Zip: ____

Home Phone: __________________ Work Phone: __________________ Ext: _________ Cellular: _____________________

Birth Date: ____________________ Soc Sec: ____________________ Drivers Lic: ______________________________

Patient Information

Address: ____

City: _______________________________ State / Zip: ____________________

Home Phone : _______________________ Work Phone: _____________________ Cellular: _________________________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated

Birth Date: ___________________ Age: __________ Soc. Sec: __________________ Drivers Lic: ___________________

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

Section 2 Employment

Employer: __________________ Position: ________________

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Section 3 Misc.

Referred By: _________________________________

Previous Dentist: ______________________________

Emergency Contact: _______________#__________

Pharmacy: ____________________________ ______

Primary Insurance Information

Name of Insured: ____ Relationship to Insured: ○ Self ○ Spouse ○ Child

Insured Soc. Sec: ________________________________Insured Birth Date: ____________________________

Ins. Company: _________________________________ Employer: ___________________________________

Ins. ID#______________________________________ Group #_____________________________________

Ins. Phone#___________________________________ Ins. Address___________________________________

Santa Rosa Dental Care

Medical History

PATIENT NAME ________________________________ BIRTH DATE ___________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? **Yes No** If yes please explain: ____________________________________

Have you ever been hospitalized or had a major operation? **Yes No** If yes please explain: ____________________________________

Have you ever had a serious head or neck injury? **Yes No** If yes please explain: ____________________________________

Are you taking any medications, pills, or drugs? **Yes No** If yes please explain: ____________________________________

Are you taking BISPHOSPHONATES currently or in the past? **Yes No** If yes please explain:______________________________

Do you use tobacco? **Yes No** ____

Do you use controlled substances? **Yes No** ____

Women: Are you…

Pregnant/Trying to get pregnant? **Yes No** Taking oral contraceptives? **Yes No** Nursing? **Yes No**

Are you allergic to any of the following (please circle the ones that apply to you)…

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Comments:____

Office Use Only

Doctor Comments:____

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 patients) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN ______________________________ DATE ____________________

DOCTOR SIGNATURE ____DATE____________________

We Want to Take Care of Your Concerns and Needs First….

Patient Name________________________ DOB_______________

What are you present dental problems? ____
____

Do your gums bleed when you use…

( ) Manual toothbrush ( ) Electric toothbrush ( ) Floss ( ) Waterpik

Are your teeth sensitive to…

( ) Sweet ( ) Hot ( ) Cold ( ) Biting pressure

Would any of these be a concern for you?

( ) Fear ( ) Time ( ) Budget ( ) Poor dental health ( ) No trust

Does dental treatment make you nervous?

( ) No ( ) Slightly ( ) Moderately ( ) Very

These are all important values to us, but what is the most important to you regarding your dental care?

( ) Cosmetics ( ) Function ( ) Comfort ( ) Longevity

If I could change my smile I would make my teeth…

( ) Whiter ( ) Straighter ( ) Close Spaces ( ) Repair Chips

What are the most important qualities you want to see in a doctor?

( ) Nonjudgmental ( ) Punctual ( ) Educated ( ) Educate patient ( ) Honesty

Any other concerns/needs of mine are:____

____

When was the last time you saw the dentist? ____________________________________

Informed Consent

I understand that by signing below and initialing any of the following items that I request and authorize the procedure to be done and have read and understand the possible risks and complications of the procedure(s). **Initials______**

X-Rays & Examination

I understand that I will be receiving a dental examination from a state licensed dental practitioner. I understand that while X-rays are taken on my teeth that I will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant radiation exposure poses a serious threat to the life and health of my unborn child. **Pregnant women are required to have medical release from their Medical Doctor prior to X-rays and Dental treatment.** **Initials_____**

Changes in Treatment Plan

I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while Working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and/or all changes and additions as necessary. **Initials_____**

Drugs and Medication

I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. **Initials______**

Removal of Teeth

Alternatives for tooth removal have been explained to me (root canal therapy, crowns, and periodontal surgery) and I authorize the Dentist to remove the following teeth ______________________________ and any others necessary for reasons in paragraph #2. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the following risks involved in having teeth removed; these are pain, spread of infection, dry socket, swelling, fractured jaw, loss of feeling in my teeth, lips, tongue, and surrounding tissue that can last for an indefinite period of time. I understand I may need further treatment by a Specialist, the cost of which is my responsibility. **Initials______**

Crowns and Bridges.

I understand that I may be wearing temporary crowns, and that I must be careful to ensure that they are not removed until the permanent crowns are delivered. I understand that sometimes it is not possible to match the color of my natural teeth with artificial teeth. I realize the last opportunity to make changes in my crown, cap, or bridge will be before permanent cementation. I must return to the dentist for permanent cementation within 20 days from tooth preparation. Extended delays between the time of tooth preparation and crown cementation may allow for tooth movement, accumulation of bacteria, and/or infection of tooth structure and the surrounding tissues. This may cause the necessity to remake the crown, cap, or bridge, and even could lead to tooth loss. I understand there will be additional charges for remakes due to my delaying permanent cementation. **Initials______**

Root Canals/Endodontic Treatment

I understand that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that sometimes root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers can separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment. **Initials______**

Periodontal Loss

I understand that I have a condition that causes gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have future adverse effect on my periodontal condition. **Initials______**

Fillings

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal may be needed, even though the tooth may not have hurt prior to the filling being done. **Initials______**

Dentures

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. (Initials_____) I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges. Initials______

I understand that there has been no guarantee or assurance made by anyone in regards to my dental treatment that I have authorized. I also acknowledge that I am responsible for payment of all my dental fees regardless of any dental insurance coverage. If you are unable to keep an appointment, please notify us at least 48 hours in advance. Failure to do so will result in a broken appointment fee of $61 per hour for general appointments and $100 for specialty appointments that were reserved for you.

Print Name ____

Patient Signature____**Date**_________________

Signature of Staff Member____Date_________________

Santa Rosa Dental Care

Office Policies

At Santa Rosa Dental Care, we are committed to excellence in providing you dental care. We believe that our relationship with you, needs open and clear communication. We will do our best to communicate all of your dental needs and estimate your financial information as soon as it is available. We want you to be as informed as possible to help you in your decisions concerning your dental health.

Please review the following policies and initial when completed. Please speak to one of our team members if you have any questions.

Financial Policy

The cost of your dental treatment will vary depending on your individual needs. The total cost of treatment is the patient's responsibility even if the patient has insurance. Our team will be happy to discuss the proposed treatment plan and the estimated fees with you. It is our policy to receive payment at the time of service.
In the event your account carries a balance we will send you a statement by mail and/or email. There is a finance fee of 1.5% charged every 30 days a balance is on the account. Accounts with a balances over 90 days may be sent to collections.
For your convenience our practice accepts payments by Cash, Personal check, Visa, Master Card, American Express, Discover and Apple Pay. We also offer outside interest free financing through Care Credit. Please speak to one of our team members for more details or you can visit CareCredit.com for more information.

Initials__________

Insurance Policy

Your insurance is a contract between you and the insurance company. To avoid misunderstandings regarding dental insurance, please review the following:

- It is your responsibility to inform us of any changes in your insurance coverage.
- We will provide a treatment plan that will show the total cost of treatment, what the insurance is *estimated* to pay and your *estimated* portion due. Keep in mind that there are hundreds of dental plans out there. We will do our best to provide you with the best estimate. Ultimately you are responsible for the total cost of treatment.
- As a courtesy, we will submit the dental claim to your insurance with any necessary documents on your behalf. We will accept the estimated insurance payment directly from your insurance company. If your insurance company pays less then what was estimated for any reason you will be responsible for the remaining balance.
- At any time you have any questions about your insurance or treatment estimate please call our office and speak to a team member or call your insurance company. They are there to help you the policy holder.

Initials__________

Appointment Policy

Your scheduled appointment is reserved exclusively for you. We have a 48 hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if a 48 business hour notice is given. If sufficient notice is not given, your account will automatically be *charged a $61* missed appointment fee per hour. If your appointment is with one of our Specialist (Oral Surgeon or Endodontist) the *missed appointment fee is $100 per hour*. As a courtesy we will call, text and email you reminders of your appointment dates and times. We ask that you make every effort to keep your reserved time.

Initials__________

Please Print Name____ Date______________________________

Signature____ Emp Initial______________________________

By signing you have confirmed that you have read and understand our office policies.

Medical Information Release Form
(HIPAA Release Form)

Name: ___________________________________ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; Examination rendered to me and claims information. This information may be released to:

☐ Spouse____
☐ Child(ren)_____________________________________
☐ Other____

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call:
[ ] My home [ ] My work [ ] My cell Number:__________________

If unable to reach me:

[ ] You may leave a detailed message
[ ] Please leave a message asking me to return your call
[ ] ____

The best time to reach me is (*day*)___________________ between (*time*)_________

Signed: ______________________________________ Date: ____/____/_____

Jeffrey C. Elliott, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

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
□ Communications barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement □ Other (Please Specify)

© 2002 American Dental Association
All Rights Reserved
Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

SANTA ROSA 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 April 14, 2003 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 terms 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 using the information listed at the end of this Notice.

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.

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 military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of 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 in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $ .75 for each page, $30.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jeffrey C. Elliott D.D.S.

Telephone: (707) 546-0429 Fax: (707) 546-3948

Address: 301 College Avenue, Santa Rosa, Ca 95401