CALL D·D·S Family Dentistry

(208) 233-2500

1352 E Center
Pocatello, ID 83201

Patient Registration Form

1 Patient Information

Today's Date

Name

Address

City | State | Zip

Phone Number | Alternate Phone Number

Email Address | Birthdate

2 Employer Information

Employer Name | Employee Occupation

Employer Address

City | State | Zip

Employee Name (Person responsible for patient)

Employee Social Security Number | Employee Phone Number

Dental Insurance Group# | Dental Insurance ID

3 General Information

Emergency Contact

Phone Number | Alternate Phone Number

How did you hear about us?

Other

Patient Dental Questions

We want to help you with any discomfort or problems you may be experiencing! That's why the more accurate you are with the answers to the questions below, the better we can help. Your answers are always strictly confidential.

1. Are you having any discomfort at this time? ◯ Yes ◯ No

2. Have you ever had problems with previous dentistry? ◯ Yes ◯ No

3. Does dental treatment make you nervous? ◯ No ◯ Slightly ◯ Moderately ◯ Extremely

4. What was the date of your last dental visit? _____

5. Have you ever been treated for any type of gum problems? ◯ Yes ◯ No

6. How often do you brush your teeth? _____

7. Are you happy with the appearance of your teeth? ◯ Yes ◯ No

If not, what would you change? _____

8. Do you have now (or have you ever had) any of the following? (If yes, check the box)

Mouth Problems

- Bleeding/sore gums..... ☐
- Unpleasant taste/bad breath..... ☐
- Burning tongue/lips..... ☐
- Frequent blisters..... ☐
- Swelling/lumps in mouth..... ☐
- Ortho treatment (braces)..... ☐
- Biting cheeks/lips..... ☐
- Clicking/popping jaw..... ☐
- Difficulty opening or closing jaw. ☐
- Headaches..... ☐

Tooth Problems

- Loose Teeth..... ☐
- Sensitive to hot..... ☐
- Sensitive to cold..... ☐
- Sensitive to sweets..... ☐
- Sensitive to biting..... ☐
- Food stuck in teeth..... ☐
- Clenching/Grinding..... ☐
  - *If so, when?* _____
- Shifting in bite..... ☐
- Change in bite..... ☐

9. Do you use the following?

- Fluoride Rinse..... ☐
- Dental Floss..... ☐
  - *If so, how often?* _____
- Electric Toothbrush..... ☐
- Water Pick..... ☐
- Other _____

Medical History Questions

1 Have you had any serious illness, had an operation, or been hospitalized in the past 5 years?

Yes ○ No ○

If yes, describe below

2 Are you under the care of a physician? Yes ○ No ○

Physician Name

Physician Phone

Are you in good health? Yes ○ No ○

Has there been any change in health in the last year? Yes ○ No ○

If yes, describe conditions being treated:

3 Do you wear contacts? Yes ○ No ○

Are you taking or scheduled to begin taking either alendronate (Fosamax) or risendronate (Actonel) for osteoporosis, Paget's disease, or cancer?

Yes ○ No ○

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?

Yes ○ No ○

Date treatment began:

4 Do you use marijuana or other recreational drugs?

Yes ○ No ○

Do you use tobacco (smoking, snuff, chew, bidis)?

Yes ○ No ○

If yes, are you interested in quitting?

Yes ○ No ○

Do you drink alcoholic beverages?

Yes ○ No ○

If yes, how much did you drink in the past 24 hours?

If yes, how much do you typically drink a week?

5 **Allergies:** Are you allergic to or have you had a reaction to any of the following?

Local anesthetics	Yes ○	No ○	Metals	Yes ○	No ○
Aspirin	Yes ○	No ○	Latex (rubber)	Yes ○	No ○
Penicillin or other antibiotics	Yes ○	No ○	Iodine	Yes ○	No ○
Barbituates, sedatives, or sleeping pills	Yes ○	No ○	Hay fever / seasonal	Yes ○	No ○
Sulfa drugs	Yes ○	No ○	Animals	Yes ○	No ○
Codeine or other narcotics	Yes ○	No ○	Food	Yes ○	No ○

Other (Specify)

If you answered yes to any of the allergies, specify reaction type:

Women Only Are you:

Pregnant? Yes ○ No ○ *If so, number of weeks:* Nursing? Yes ○ No ○

Taking birth control pills or hormonal replacement? Yes ○ No ○

Medical History Questions (Continued)

Please indicate if you have ever had one of the following diseases or problems by checking yes or no.

	Yes	No
Abnormal bleeding	○	○
AIDS or HIV Infection	○	○
Anemia	○	○
Arthritis	○	○
Rheumatoid Arthritis	○	○
Asthma	○	○
Blood transfusion	○	○
If yes, date of last transfusion		
Cancer/Chemotherapy/Radiation Treatment	○	○
Cardiovascular Disease: *If yes, specify type*	○	○
Angina ☐	Damaged heart valves ☐	
Artificial heart valves ☐	Heart attack ☐	
Congenital heart defects ☐	High blood pressure ☐	
Congestive heart failure ☐	Low blood pressure ☐	
Coronary artery disease ☐	Pacemaker ☐	
Chest pain upon exertion	○	○
Chronic Pain	○	○
Disease, drug or radiation induced immunosuppression	○	○
Diabetes	○	○
Type I (Insulin dependant) ☐	Type II ☐	
Dry Mouth	○	○
Eating Disorder	○	○
If yes, specify:		
Epilepsy	○	○
Fainting spells or seizures	○	○
G.E. Reflux/persistent heartburn	○	○
Glaucoma	○	○

	Yes	No
Human Papilloma Virus (HPV)	○	○
Hepatitis, jaundice, or liver disease	○	○
Recurrent Infections	○	○
If yes, indicate type		
Kidney problems	○	○
If yes, indicate type		
Mental health disorders	○	○
If yes, please specify		
Malnutrition	○	○
Neurological disorders	○	○
If yes, please specify		
Osteoporosis	○	○
Persistent swollen glands in neck	○	○
Respiratory problems.	○	○
If yes, please specify		
Sexually transmitted disease	○	○
Sinus trouble	○	○
Sleep disorder	○	○
Sores or ulcers in the mouth	○	○
Stroke	○	○
Systemic lupus erythematosus	○	○
Tuberculosis	○	○
If yes, date		
Thyroid problems	○	○
Ulcers	○	○

Are there any diseases, conditions, or problems that are not mentioned on this form, that you would like us to know about? If so, please explain:

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____Signature of Patient/Legal Guardian _____Date

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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

YOUR RIGHTS:

When it comes to your health information, you have certain rights.

GET AN ELECTRONIC OR PAPER COPY OF YOUR MEDICAL RECORD

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES :

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

IN THESE CASES, YOU HAVE BOTH THE RIGHT AND CHOICE TO TELL US TO:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

IN THESE CASES WE NEVER SHARE YOUR INFORMATION UNLESS YOU GIVE US WRITTEN PERMISSION:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

IN THE CASE OF FUNDRAISING:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES:

How do we typically use or share your health information? We typically use or share your health information in the following ways:

TREAT YOU

- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

BILL FOR YOUR SERVICES

- We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

- We can use or share your information for health research
- Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

- We can share health information about you with organ procurement organizations
- Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
  For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

AppointmentPolicy

We value your time, and we hope that you value ours. If you miss an appointment, we reserve the right to charge you a $50 no-show fee. In addition, if you miss an appointment three times, we reserve the right to dismiss you as a patient.

Check here to acknowledge that you understand our appointment policy: ☐