Patient Registration Form

American Dental Association
www.ada.org

Email:			Today's Date:
Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.		Referred by:	
Name: Last First Middle		Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )
Address: Mailing address		City:	State: Zip:
SS#:		Date of Birth:	Sex: M F
Employer:		Business Phone: *include area code* ( )	
Emergency Contact:	Relationship:	Home Phone: *include area code* ( )	Cell Phone: *include area code* ( )

College Student Status:	❑ Full Time	❑ Part Time	Please provide school info:	School Name:_____
Employment Status:	❑ Full Time	❑ Part Time	❑ Retired	Address:_____
Marital Status:	❑ Married	❑ Single	❑ Divorced ❑ Separated ❑ Widowed	Address 2:_____
Pref. Pharmacy:		Phone: ( )		City, State, Zip:_____

Dental Insurance Information

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ❑ 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: _____

ID#: _____ Gr#: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ❑ 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: _____

ID#: _____ Gr#: _____

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

over

Medical Information Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Physician Name: _____			
Phone: *include area code* (____) _____			
Address/City/State/Zip: _____			
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
If yes, what condition was treated? _____			
Date of last physical exam: _____			
Do you wear contact lenses?	☐	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)?	☐	☐	☐
Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
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 metastic cancer?	☐	☐	☐
Date Treatment Began: _____			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem? _____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____			
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormone replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ☐ ☐ ☐
Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to, or have you had a reaction to: To all yes responses, specify type of reaction.	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbituates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever / seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

	Yes	No	DK
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Congenital heart defects	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/Persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: _____			
Recurrent infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ Migraines	☐	☐	☐
Severe of rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐
Name of physician or dentist making recommendation: _____ Phone: (____) _____
Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. 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: _____

Financial Agreement

- I understand that my insurance coverage is a contract between my employer and the insurance company. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. **Initials**_____
- I understand that my dental care provider has a relationship with me and not my insurance company. I understand that my provider will file my insurance claims as a courtesy, but my provider cannot guarantee my insurance company will pay on any claims. **Initials**_____
- I understand that my provider accepts the following forms of payment: Cash payments, Care Credit, Visa, MasterCard, Discover, Debit Cards with the Visa or MasterCard logo, and personal checks. **Initials**_____
- I understand that there will be a $35.00 insufficient funds fee added to my account in the event of a returned check. **Initials**_____
- I understand that my appointment time has been especially reserved for me, and in the event that I need to reschedule, I will give a 48-business hour notice. **Initials**_____
- I understand that it is my responsibility to advise this office of any changes in the information I provide regarding my insurance, patient information, or the health history form. **Initials**_____
- I understand that fees are applicable for cpopies of dental records and/or copies of dental x-rays.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with

_____and assign directly to **TBD I, PLLC** all insurance benefits, if
(Name of insurance Company(ies)

any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and my disclose such information to the above-name Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

TBD I, PLLC - Dental
Excellence
1288 W. Orange Grove Rd.
Tucson
Arizona, 85704

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at TBD I, PLLC - Dental Excellence understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 02/08/2021, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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 may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

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

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 purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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 authorized 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.

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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages 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, mailing, 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 an alternative format,

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 at 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 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 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.

Privacy Officer: Lorena Lucero
Telephone: 5205758800
E-mail: lorena@belldentalarts.com
Address: 1288 W. Orange Grove Rd.
Zip Code: 85704
State: Arizona
City: Tucson

TBD I, PLLC -

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgment"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____
_____
_____