**PATIENT REGISTRATION & INSURANCE INFORMATION**

**Welcome to our office!**
**Please provide us with the information requested below. All information is kept confidential.**

## PATIENT INFORMATION

Patient's Name: ______________________________________ Age: ________ Date of Birth: ___________________

Male Female SSN: _________________________ Driver's License #: __________________________

Address: ______________________________________________ City: _______________________ Zip: ___________

Home Phone: ________________________ Cell: _____________________ Work: _____________________________

E-Mail: _________________________________ How did you hear about us? _______________________________

Preferred Pharmacy: _____________________________ Pharmacy Address: _________________________________

Emergency Contact: _____________________________ Emergency Contact Phone #: __________________________

Referring Dentist/Orthodontist: ______________________________ Are you currently in pain? Yes No

Reason for Visit: ____________________________________________________________________________________

## GUARANTOR (IF SELF, PLEASE LEAVE BLANK)

Guarantor Name: ________________________________________ Relationship to Patient: _____________________

Address: _______________________________________________City: _________________________ Zip: __________

SSN: _______________________ Phone: ________________________ Employer: ______________________________

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## DENTAL INSURANCE INFORMATION

Insurance Company: ______________ Policy Holder Name: __________________________Date of Birth: ___________

Ins. Phone #: ________________________ID or SSN: ______________________________ Group #: ______________

Policy Holder's Address (if different from Patient's): ______________________________________________________

## PAYMENT and INSURANCE POLICIES

**Payment is due at time of service. If we have not received payment from your insurance within 60 days of service, the balance becomes your responsibility. Unpaid balances older than 90 days are subject to 20% annual interest.**
For our patients with PPO dental insurance, we will bill your insurance as a courtesy. This contract is between you and your insurance company, and you are fully responsible for any amount not paid by your insurance. There is no guarantee that your insurance will pay. If any part of the insurance claim is denied, **you are responsible for the full balance of your bill within 30 days of denial notice.** We will not enter into a dispute with your insurance company. This is your responsibility and obligation.
For those with HMO insurance, we have an agreement with approved fees for services with your insurance carrier. We are only authorized to perform those agreed upon (Pre-Authorized) services. Should you and our doctor mutually decide to perform services outside this contract, you are responsible for payment of those fees.

**______Initials I acknowledge that I have read and understand the above insurance and payment policies.**

_______________________________________ ____________ ________________________________________

**Patient Signature (or legally authorized individual) Date Relationship to patient (parent, legal guardian, etc.)**

## MEDICARE/MEDI-CAL/MEDICAID

Our doctors are not providers for Medicare, Medi-Cal or Medicaid or supplements. Medicare does not cover dental-related procedures. We do not bill Medicare, Medi-Cal or Medicaid or supplemental insurances. We are happy to see you as a patient, but the total bill is your responsibility. I agree that I will not try to get reimbursement from Medicare and do not expect Ocean Oral Surgery to bill for me. I am responsible for all fees at the time of service. **Any unpaid balance older than 90 days is subject to 20% interest annually.**

**______Initials I acknowledge that I have read and understand the above regarding Medicare.**

## X-RAY SERVICES and COMPUTERIZED TOMOGRAPHY (CT) SCANS

Full-sized, clear and current digital panoramic or cone-beam CT X-Rays are necessary for diagnosis and planning of treatment and are mandatory for medical, legal and insurance purposes. We do not take X-Rays unnecessarily.

A CT (computerized tomography) scan is an X-Ray producing images showing internal structures in cross sections rather than the overlapping images typically seen in conventional X-Rays. A conventional X-Ray of your mouth limits your dentist to 2-D Visualization. Diagnosis and treatment planning can require a more complete understanding of a complex 3-D anatomy. CT examinations provide a wealth of 3-D information that can be used when planning for dental implants, surgical extractions, maxillofacial surgery and advanced dental restorative procedures. One benefit of CT scans is the greater chance for diagnosing conditions such as vertical root fractures, which can be missed a significant percentage of the time on conventional films, ultimately helping patients avoid unnecessary additional treatment. The CT scan enhances your dentist's ability to see what he needs to see before treatment is started.

**CT scans are NOT recommended for pregnant women because of danger to the fetus. Please check below:**

**I am pregnant** **I am not pregnant** **I am unsure whether I am pregnant**

RISKS: CT scans, like conventional X-rays, expose you to radiation. The amount of radiation you will be exposed to by the CT scan used by this office is approximately the equivalent to the exposure you would get from minutes in the sun. **Our CT produced dental images are obtained with 1/3 less radiation exposure than a Full Mouth X-Ray series**. An alternative to CT scans is conventional X-rays. Our office can e-mail the alternative images to your physician/dentist, if requested.

**Concerned about radiation exposure? Here are the facts:**
Our Cone Beam CT Machine uses 0.04% of the radiation used for a traditional medical head CT.

- Average Background Exposure: 2500 – 4000 uSv/year
- **Panoramic X-Ray Exposure: 3-8 uSv**
- **CBCT Scan Exposure: 32-40 uSv**
- London/New York Round Trip Flight: 100 uSv
- Chest X-Ray Exposure: 100 uSv
- Full Mouth Dental X-Ray Exposure: 50-100 uSv

**I, _________________________________,** being 18 years or older, certify that I have read and understood the above, its benefits, risks and alternatives. CT scans are deemed necessary at the time of your consultation; risks/benefits will be discussed at that time with your rendering provider.

Most dental insurances do not pay for Computerized Tomography. We submit all treatment to insurance for payment. However, most insurance plans do not reimburse for CT scans. **Please be aware that this $250 fee will be your responsibility.**
**Please sign this form only if you have read, understood and agree with its contents.**

**Patient Name ___________________________________________________ Date of Birth: ________________**

___________________________________________ ____________ _____________________________________________
**Patient Signature (or legally authorized individual)** **Date** **Relationship to patient (parent, legal guardian, etc.)**

# Medical History

Name: ________________________________________ Date: ______________________

Date of Birth: __________ Sex: M F Height: ________ Weight: ______________________

______________________________________________________________________________

**For the following questions, circle Y or N. Your answers are for our records only and are kept confidential.**

1. Are you in good health? ............................................ Y N
2. Has there been any change in your health in the past year? ............................................ Y N
3. My last physical exam was on ________________________________.
4. Are you now under the care of a physician? ............................................ Y N
   If so, for what condition? ________________________________________________
5. My physician's name and address is: ________________________________________________

   ________________________________________________________________________
6. Have you had any serious illness, operation or hospitalization within the past five years? ............... Y N
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? ............................................ Y N
8. Are you taking or have you ever taken bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia or Zometa)? ............................ Y N
9. Are you taking any medicine including diet pills, non-prescription, vitamins, homeopathic or natural remedies?
   If so, please list: ________________________________________________ Y N
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur ............................................ Y N
    b. Rheumatic heart disease ............................................ Y N
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition? ............................................ Y N
       i. Chest pain upon exertion? ............................................ Y N
       ii. Shortness of breath after mild exercise? ............................................ Y N
       iii. Do your ankles swell? ............................................ Y N
    d. Allergies ............................................ Y N
    e. Sinus trouble ............................................ Y N
    f. Asthma or hay fever ............................................ Y N
    g. Fainting spells or seizures ............................................ Y N
    h. Diabetes ............................................ Y N
    i. Hepatitis, jaundice or liver disease ............................................ Y N
    j. Frequent or recurring mouth sores ............................................ Y N
    k. Thyroid problems ............................................ Y N
    l. Respiratory problems, emphysema, bronchitis, etc. ............................................ Y N
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) ............................................ Y N
    n. Osteoporosis ............................................ Y N
    o. Stomach ulcer or hyperacidity ............................................ Y N
    p. Kidney trouble ............................................ Y N
    q. Tuberculosis ............................................ Y N
    r. Persistent cough or cough that produces blood ............................................ Y N
    s. Persistent swollen neck glands ............................................ Y N
    t. Low blood pressure ............................................ Y N
    u. Epilepsy or neurological disorder ............................................ Y N
    v. Cancer ............................................ Y N
    w. Any disease, drug or transplant operation that has depressed your immune system? Y N

11. Have you had abnormal bleeding? ........................................ Y N
    Have you ever required a blood transfusion? ........................................ Y N
12. Do you have any blood disorder such as anemia? ........................................ Y N
13. Have you ever had treatment for a tumor or growth? ........................................ Y N
14. Have you had radiation therapy to the head, neck or jaws? ........................................ Y N
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics ........................................ Y N
    b. Penicillin or antibiotics ........................................ Y N
    c. Sulfa drugs ........................................ Y N
    d. Barbiturates or sleeping pills ........................................ Y N
    e. Aspirin ........................................ Y N
    f. Iodine ........................................ Y N
    g. Codeine or other narcotics ........................................ Y N
    h. Latex or rubber products ........................................ Y N
    i. Intravenous anesthesia ........................................ Y N
    j. Other ________________________________________
16. Have you had any serious trouble associated with previous dental treatment? ........................ Y N
    If so, please explain: ________________________________________
    ________________________________________
17. Do you have any other condition or disease you think the doctor should know about? Y N
    If so, explain: ________________________________________
18. Do you smoke or chew tobacco? ........................................ Y N
    How much/often? ______________________________
19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? ........................................ Y N
20. Are you wearing contact lenses? ........................................ Y N
21. Are you wearing removable dental appliances? ........................................ Y N
22. Do you wish to talk privately with the doctor about anything? ........................................ Y N

**Women**

23. Are you pregnant or trying to become pregnant? ........................................ Y N
24. Do you have problems associated with your menstrual period? ........................................ Y N
25. Are you nursing? ........................................ Y N
26. Are you taking birth control pills? ........................................ Y N

**Chief Dental Complaint:** ________________________________________
________________________________________

I have read and understand this form. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to complete this form honestly and completely.

**Patient's Signature** ______________________________ **Date** ____________________

**Doctor's Signature** ______________________________ **Date** ____________________

# Notice of Privacy Practices

**This notice describes how your health information may be used and disclosed, and how you can access it.**

We are required by law to keep your health information secure and confidential. Also by law we need to give you this notice and to follow the terms of this notice. We are permitted to use or disclose your health information to those involved in your treatment. For example, we may have a doctor whom we involve in your care review your case. We may use or disclose your health information for payment of 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 normal healthcare operations. For example we may enter your treatment information into our computer system.
We may share your medical information with 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 phone.

In an emergency we may disclose 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 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 normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will use whatever communication method, number or system you prefer. 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 wish to see. If you want a copy of your records, we may charge you a reasonable fee for 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 accommodate 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 people to which we disclose your information. 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 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 at 200 Independence Avenue SW, Room 509F, Washington, DC 20201, online at www.hhs.gov or by email at OCRComplaint@hhs.gov. You will not be retaliated against for filing a complaint. Please contact our Privacy Officer, Cristina Robinson, at 805.682.0933 for more information, to make a request, fine a complaint or for assistance regarding your health information privacy.

Acknowledgment: I have received a copy of Ocean Oral Surgery's Notice of Privacy Practices.

Signed____________________________ Date____________ Print Name __________________________________

If signing as a parent or guardian, patient's name ______________________________________________________