



**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient is:  Policy Holder Preferred Name: \_\_\_\_\_

Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Driver's Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Driver's Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail

Section 2

Section 3

Employment Status:  Full Time  Part Time  Retired

Cell Phone #: \_\_\_\_\_

Student Status:  Full Time  Part Time

Emergency Phone #: \_\_\_\_\_

Thank Referral Y/N?: \_\_\_\_\_

Patient Preferences - Correspondence

Email  Phone:  Before Noon  After Noon  After 5pm

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Patient  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Patient  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

To the best of my knowledge, the questions on this form have been accurately answered.

SIGNATURE OF PATIENT, PARENT or GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

**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: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you  Pregnant/Trying to get pregnant?  Nursing?  
 Taking oral contraceptives?

Are you allergic to any of the following? \_\_\_\_\_

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other If yes, please explain: \_\_\_\_\_

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

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Herpes	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Yellow Jaundice

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

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

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

(DENTAL)

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED  
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your medical information.

We may use and disclose you medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of your protected health information.
- The right to obtain a paper copy of this notice from us upon request.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

SEAN WILSON, D.D.S.  
98 MONTGOMERY DRIVE  
SANTA ROSA, CA 95404

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third party payors.**
- **Conduct normal health care operations such as quality assessments and physician certifications.**

I have received, read and understand your ***Notice of Privacy Practices*** (attached) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing an explanation of how you restrict the use and disclosure of my private information to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if this organization does agree, then this organization is bound to abide by such restrictions.

**Patient Name** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

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**DENTAL “BENEFITS” ACKNOWLEDGEMENT**

It is our goal to provide the best dentistry for you. In order to do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based on your needs, and we assume that you are as concerned as we are about maintaining your good health.

The term “dental insurance” is misleading. What is commonly known as “dental insurance” is more correctly termed dental “supplement”. Dental benefits are not intended to pay everything, but to assist with the costs of dental treatment. Generally, dental benefits pay a percentage of each procedure up to a set yearly maximum. The benefits available to you are established by which plan package your employer has purchased, and it is possible your employer may change your benefits package at will without notifying our office. To avoid confusion, we recommend that you call your insurance carrier on the day prior to having any dental treatment to ensure eligibility and that the dental treatment estimate presented by our office is consistent with your employer’s most current benefit package. Please let our office know if we need to be aware of any inconsistencies.

As a courtesy to you, we will submit claims to your dental plan carrier. We also accept benefit assignment, meaning that we will estimate expected benefit payment and allow you to pay your estimated portion at the time services are provided. However, we do not guarantee an estimate and should your dental plan pay less than expected, you are fully responsible for the balance. We cannot take responsibility for any denial by your dental plan(s).

We value you and your family as patients and friends. We strive to do our very best in accurately estimating your patient portion responsibility, however, your dental health is our first concern. We welcome any comments or feedback on how we can better assist you.

**I have read the above information and understand that I am responsible for familiarizing myself with all aspects of my benefits. I also understand that I am responsible for charges not covered by my plan.**

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**Signature of Patient, Parent or Guardian**

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**Date**

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## OFFICE POLICY

Thank you for choosing our practice as your dental provider. In order to make our relationship work more effectively, we would like to make you aware of our office policy.

While we very much value our patients, failure to keep scheduled appointments may result in a \$75 charge. Our cancellation policy requires a telephone call at least two business days (48 hours) prior to scheduled appointments to avoid a cancellation charge. Please be advised our office is closed on Friday so Monday appointments must be cancelled no later than Thursday to avoid a cancellation charge.

Payments for dental services are due in full on the day of your dental appointment, unless other arrangements are made in advance. We accept Cash, Checks, Visa, MasterCard, American Express, or Debit Card. We also offer *CareCredit* Financing for those who are looking for extended payments at zero or a very low interest rate.

For those patients who have dental insurance, we are happy to process your claims for maximum reimbursement. However, any portion that is not covered by insurance is due on the day of your appointment unless other arrangements have been made in advance.

Please let us know if you have any questions regarding our office policy.

**I have read and understand the office policy as outlined above. I understand my financial responsibility.**

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Signature of Patient, Parent or Guardian

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Date

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