ADULT REGISTRATION

PATIENT INFORMATION AND HEALTH HISTORY FORM
INFORMACION DEL PACIENTE

Full Name (nombre del joven): ____________________________________

Date of Birth (Nacimiento) : _____/_____/_____ Age (edad) : _______

Sex (sexo) : ▪Male ▪Female

Address (Dirección): ____

City(ciudad): _______________________ State(estado) : ______________

Zip Code (código postal): ________________

Best Number to Reach You (teléfono) : ____________________Mobile (móvil):____________

Employer (empleador): ____

What is your primary language? ______________________

(¿Cuál es el idioma primario del padre?)

EMERGENCY CONTACT
CONTACTO DE EMERGENCIA

**Please list someone other than yourself.*

Name (Nombre): ____

Relationship (relación): ____

Home Phone (Teléfono): ____

Work Phone (teléfono del rabajo)_____________Mobile(móvil):________________________

MEDICAL HISTORY
HISTORIA MEDICA

- *For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please not that during your child's initial visit you and your child will be asked some questions about your responses to this questionnaire and there may be additional questions concerning his/her health. If you have any questions, please feel free to ask.*
- *Por favor conteste las siguientes preguntas de la forma "si" o "no", marcando sus respuestas con un circulo. Su informacion es confidencial y protegida por ley. Durante su visita, el doctor solicitara mas informacion de ud, y del joven paceiente. Por Favor estese preparado a elaborar sobre sus respuestas a estas y otras preguntas relacionadas a la salud del paciente. Si usted o el joven tienen cualquier pregunta o preocupacion, por favor mencionenlas; el doctor esta mas que disponible para ofrecerle una respuesta.*

General Conditions

Arthritis	Yes	No	Gastrointestinal disorders	Yes	No
Asthma	Yes	No	Heart disease	Yes	No
Diabetes	Yes	No	Heart murmur	Yes	No
Kidney disease	Yes	No	Rheumatic fever	Yes	No
Thyroid Problems	Yes	No	High Blood Pressure	Yes	No
Liver Disease	Yes	No			

Hematological (Blood-related)

Anemia	Yes	No	Bleeding (prolonged)	Yes	No
Hemophilia	Yes	No	Sickle cell trait	Yes	No
Sickle cell disease	Yes	No	Transfusion of blood	Yes	No

Behavior/Learning

ADHD	Yes	No	Anxiousness/Nervousness	Yes	No
Autism	Yes	No	Behavior issues	Yes	No
Emotional disability	Yes	No	Learning disability	Yes	No
Psychiatric disorder	Yes	No			

Infectious

Hepatitis	Yes	No	HIV infection (AIDS)	Yes	No
Tuberculosis	Yes	No	Venereal disease	Yes	No

Developmental

Brain injury	Yes	No	Cerebral palsy	Yes	No
Cleft lip/palate	Yes	No	Developmental delay	Yes	No
Growth problems	Yes	No	Feeding/eating problems	Yes	No
Hearing loss	Yes	No	Neuromuscular defect	Yes	No
Orthopedic problem	Yes	No	Seizures, Epilepsy	Yes	No
Spina bifida	Yes	No	Other: ________________________________		

____

____

If any checked yes, please explain: ____

____

Substance Abuse

Drug use	Yes	No	Tobacco use	Yes	No
Abuse	Yes	No	Alcohol Abuse	Yes	No

Other

Cancer Yes No Type: ______________________________
Leukemia Yes No Type: ______________________________
Fainting/headaches Yes No Sleep apnea Yes No
Sleep problems Yes No Snoring Yes No

Are you currently taking any medications? Yes No
If yes, please list: ____
____
____

Any surgery? Yes No
If yes, type(s), date(s) and age(s):____
____
Have you been hospitalized? Yes No
If yes, when, and where? ____

____

Are you allergic to:

- ☐ Medications or drugs? Yes No
- ☐ Latex? Yes No
- ☐ Local Anesthetics (Lidocaine) Yes No
- ☐ Penicillin or other antibiotics Yes No
- ☐ Codeine or other narcotics Yes No
- ☐ Foods? Yes No
  If yes, please list: ____
- a. Other? Yes No
  If yes, please explain: ____

Do you have any disease, condition, or problem not listed above that you think the dentist should know about?
____
____

Are you wearing removable dental appliances? Yes No
Do you drink well water? Yes No

Women Only

Are you menstruating regularly Yes No
Are you pregnant? Yes No
Are you nursing a baby? Yes No
Are you taking type of birth control? Yes No

DENTAL HISTORY
HISTORIA DENTALES

1. Last Dental Appointment? ______________________
2. Were X-Rays taken? Yes No Date of last X-Rays? ________________
3. How often do you brush your teeth? _____________________________________
4. Do you use dental floss? Yes No
5. Do you grind your teeth? Yes No
6. Have you had any dental or surgical treatment to the mouth? Yes No
   If yes, describe what was done and if you were sedated:
   ____
   ____

CONSENT FOR DENTAL TREATMENT
CONSENTIMIENTO PARA TRATAMIENTO DENTAL EI

To the best of my knowledge the above information is accurate. During treatment I will report any changes in my health, illness, or medications. Problems arising from dental treatment are extremely rare but may include pain or infection. Not treating dental disease may have the same result. If a tooth cavity is very deep and the nerve and blood supply are affected, or if bone loss or swelling are present, the removal of the nerve or the tooth with local anesthesia, may be necessary. Please feel free to discuss any concerns you have with the dentist. I authorize the dentist to perform a dental examination and treatments such as deemed necessary by the dentist. **Notice of Deemed Consent for HIV, HBV, and HCV Testing: If one of our health care professionals, workers, or employees should be directly exposed to blood or body fluids in a way that may transmit disease, you blood will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Virus.** A physician or other health care provider will tell you and that person the result of the test and provided counseling, if necessary. **A consent to obtain test results will be signed and sent to the health care provider so we may obtain your test results directly.** If you should be directly exposed to blood or body fluids of one of our health care professionals, workers or employees in a way that may transmit disease, that person's blood will be tested for infection with Human Immunodeficiency Virus (HIV, the AIDS Virus) and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary. I will not hold my dentist, or any other member of staff of the Community Dental Center, responsible for any errors or omissions that I may have had in the completion of this form. Also, by my signature below, I acknowledge that the Notice of Privacy practices is posted and I may request a copy at any time.

Signature: ____________________________________ **Date:** ______________________

NO SHOW POLICY

It is your responsibility to call at least 24 hours before a scheduled appointment(s) to reschedule or we will consider the appointment(s) a “No Show/No Call” and will not be able to provide another appointment time for 6 months. During the 6 month probation period, we will only see you on a walk-in, first come, first served basis. We will do our best to work you in. IT IS IMPERATIVE YOU KEEP YOUR APPOINTMENT!!!

Signature: ___________________________________ **Date:** ______________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
CONSENTIMIENTO PARA EL USO Y DIVULGACIÓN DE INFORMACIÓN DE SALUD

Patient Name: __________________________ **Date Of Birth:** _____________________

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our notice is provided upon request. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting it from us.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will no affect any action we took in reliance on this consent before we received your revocation, and that we will decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, ____________________________, have had fully opportunity to read and consider the content of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information as described in the "Notice of Privacy Practices."

Signature __________________________________ Date__________________________

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability Act of 1996 (HIPPA) 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. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA 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 health information.

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

- Treatment means providing, coordinating, or managing healthcare and related services by one of more health care providers. An example of this would be: Sending your patient records (clinical notes, treatment plan, and radiographs) to another provider via fax, mail, or email.
- Payment includes, but is not limited to, activities such as: obtaining reimbursement for services, confirming coverage, billing or collection activities and utilizations review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations are 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 identified health information by removing all reference to an individual or any individuals. 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 of you. All other uses and disclosures will be made only with your written authorization. You may revoke the authorization in writing and we are required to honor and abide by that written request, except in relation to disclosures made prior to that date.

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 information disclosed to family member, other relatives, close personal friends, or any other person you identify. We re, however, not required to agree to a requested restriction. If we do agree to restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communication of protected health information from s 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 protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of November 28, 2006 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written compliant to our Privacy Officer, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a compliant:
The US Department of Health and Human Services
Office of Civil Rights
202-619-0257
Toll Free: 1-877-696-6775