Juan Alzate Dental Corp.
ORAL SURGERY DENTAL SPECIALITIES

REGISTRATION

Patient Name	DOB	Sex M F
Address	City	Zip
Home #	Work #	Mobile
Email		
Occupation	Employer	

DENTAL INSURANCE

Subscriber Name	DOB
Subscriber ID/ SS#	
Insurance Company	Group#
Employer	
Employer Address	
Employer Phone	

ADDITIONAL DENTAL INSURANCE

Subscriber Name	DOB
Subscriber ID/ SS#	
Insurance Company	Group#
Employer	
Employer Address	Phone

Who referred you to our office? _____
In case of an emergency, whom may we contact? _____
Relationship_____Phone_____

Dr. Alzate may use my health care information and may disclose such information to the above-named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits.

SIGNATURE OF PATIENT/ GUARDIAN_____DATE_____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA 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.

OUR LEGAL DUTY: We are required by applicable federal and state law 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 04/14/03, and will remain in effect until we replace it. 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 use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your health information to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations 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 other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so. Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure 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 form of health information. Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. Required by Law: We may use or disclose your health information when we are required to do so by law. Abuse or Neglect: We may use or 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 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. Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, 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 copy expenses. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you

prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end 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 to alternate locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payment 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.

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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 or 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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. 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.

You may assign a person to whom we may release information pertaining to your dental file. Please list the name of the individual below. This person is required to show proof of identification prior to release of information.

Name of Assignee _____Relationship_____

Signature of patient/patient guardian _____Date_____

Confidential Health History

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain:
   _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?
(Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or other sedatives	Yes / No	Codeine or other narcotics
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Anti-Depressants	Yes / No	Herbal Supplements		

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____
Yes / No Have you ever taken Fen-Phen? If YES, when: _____
Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Physician's Name: _____ Phone Number: _____

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and or medication. I will not hold my dentist, or any of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) _____ Date _____

Signature of Dentist _____ Date _____

GENERAL CONSENT

I, _____ authorize the following services for the initiation of my dental examination.

I authorize photography, I understand that extra oral and intraoral photographs may be taken for dental office use and for before and after comparisons. Photographs are also taken for patient recognition.

I authorize x-rays. I understand that x-rays are necessary in order to comprehensively and thoroughly examine my oral condition. Without the use of x-ray, I understand that the examining dentist cannot see all decay that may be present, cannot evaluate my periodontal status, and cannot see radiolucent infection. I have the right to refuse x-ray and my doctor has the right to refuse dental treatment services unless x-rays are present.

I authorize drugs, medications and local anesthesia. I understand that antibiotics and analgesics and other medications can cause allergic reactions and/or anaphylactic shock.

Topical anesthetics are applied to mouth tissues with a swab in order to numb an area in preparation for administering an injection of anesthetic which prevents pain by blocking the nerves that sense or transmit pain.

I understand some complications that may occur while administering local anesthetic are not limited allergic reactions, pain, swelling and bruising. Rare and more serious complications that can occur are permanent anesthesia and in very rare cases life threatening conditions. I also understand that more than one injection may be needed to achieve satisfactory or desired results for treatment purposes.

I authorize changes in treatment plans. I understand that during treatment it may be necessary to change or add procedures that were not discovered during my initial examination. I give my permission to my dentist to make all and any changes necessary to compliment my dental condition. I have the opportunity to fully discuss all treatment options with my dentist until I am satisfied and understand the dental treatments I will have performed.

Signature of patient/ parent or guardian if minor _____Date_____

Written Financial Policy

PAYMENT OPTIONS TO CHOOSE FORM:

-Cash, Check, Visa, or Mastercard

-We offer a courtesy accounting adjustment to patients who pay for their treatment with cash or cashier's check prior to completion of care for treatment plans

-Convenient monthly payment options from CareCredit
- -allows you to pay over time*
- -no annual fees or pre-payment penalties*

Juan Alzate Dental Corp requires payment prior to the completion of treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received and associated costs for example, lab and materials.

For plans requiring more than 4 appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment*

I certify that I, and or my dependents have insurance coverage. I assign to Dr.Alzate all insurance benefits, otherwise payable to me for the 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.

A fee of $25 is charged to patients who miss or cancel an appointment without 24-hour notice. A fee of $50-100 is charged to patients who miss or cancel an appointment with a specialist without 24-hour notice.

Juan Alzate Dental Corp charges $40 for returned checks.

If you have any questions, please do not hesitate to ask.

A valid CA I.D. And insurance card is required at the time of initial appointment.

A minor must be accompanied by a Parent/or Legal Guardian at initial visit.

Patient Name (please print) _____

Signature of patient/guardian_____Date_____

* Subject to credit approval

* If we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment cost.