ROSE DENTAL GROUP & ORTHODONTICS
2731 S Rose Ave #101, Oxnard, CA 93033
OxnardRoseDental.com
(805) 483-3658

PATIENT REGISTRATION

Welcome! So that we may provide you with the best possible care, please complete the following medical/dental history forms.

Date _____

Home Phone _____ Cell Phone _____ Email _____

Patient _____ Nickname: _____ Social Security # _____
(Last, First, Initial)

Address _____ How long at this address _____
(Street, City, State, Zip)

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Other Maiden Name _____

Employed by _____ Occupation _____ No. Years Employed _____

Business Address _____ Business Phone _____

Spouse Name _____ Birth Date _____ Spouse's Social Security # _____

Spouse Employed by _____ Occupation _____ No. Years Employed _____

Who is responsible for this account? _____ Relationship to Patient _____

Dental Insurance Primary Carrier

Insured's Name _____

Insurance Co. _____

Insured's Employer _____

Insured's Soc. Sec# or ID# _____

Insured's Group # _____

Insured's Date of Birth _____

Dental Insurance Secondary Carrier

Insured's Name _____

Insurance Co. _____

Insured's Employer _____

Insured's Soc. Sec# or ID# _____

Insured's Group # _____

Insured's Date of Birth _____

How did you hear about our office? _____

If referred, whom may we thank? _____

Are there any immediate family members who have been seen in our office? (spouse or child) _____

Best phone number to call?
☐ Home ☐ Cell ☐ Work ☐ Other

How do you prefer to have your appointment confirmed?
☐ Email ☐ Text Message ☐ Phone Call/Message

This information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of these forms. If I ever have any changes in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

The patient or responsible party shall be responsible for any attorney fees, collection agency fees, cost of collection, court costs and other expenses or fees.

*Signature _____ Date _____

Patient Name

DENTAL HISTORY

PATIENT CONCERNS

Dental treatment desired

☐ Check up ☐ Cleaning ☐ Cavities Restored ☐ Missing Teeth Replaced
☐ Cosmetic Dentistry ☐ Teeth Extracted ☐ Complete Dentures ☐ Orthodontics
☐ Tooth Whitening ☐ Implants ☐ Other _____

Concerns with treatment

☐ Fear ☐ Time ☐ Health ☐ Pain
☐ Cosmetic ☐ Prevention ☐ Money ☐ Function
☐ Other _____

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____ Reason for Leaving _____

_____

How often do you visit a dentist? _____ How often do you have your teeth cleaned? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (toothpick, etc.) _____

Do you have any dental problems now? ☐ Yes ☐ No If yes, please describe _____

_____

Are any of your teeth sensitive to:

Hot or cold? ☐ Yes ☐ No
Sweets? ☐ Yes ☐ No
Biting or chewing? ☐ Yes ☐ No

Have you ever had:

Orthodontic treatment? ☐ Yes ☐ No
Oral Surgery? ☐ Yes ☐ No
Periodontal treatment? ☐ Yes ☐ No
Your teeth ground or the bite adjusted? ☐ Yes ☐ No
A bite plate or mouth guard? ☐ Yes ☐ No
A serious injury to the mouth or head? ☐ Yes ☐ No
If so, please describe, including cause
_____
_____
_____
_____

Do you:

Clench or grind your teeth while awake or asleep? ☐ Yes ☐ No
Bite your lips or cheeks regularly? ☐ Yes ☐ No
Have tired jaws, especially in the morning? ☐ Yes ☐ No
Smoke/chew tobacco? ☐ Yes ☐ No

Have you experienced:

Clicking or popping of the jaw? ☐ Yes ☐ No
Pain? (joint, ear, side of face) ☐ Yes ☐ No
Difficulty in opening or closing the mouth? ☐ Yes ☐ No
Difficulty in chewing on either side of the mouth? ☐ Yes ☐ No
Headaches, neck aches or shoulder aches? ☐ Yes ☐ No
Sore muscles (neck, shoulders) ☐ Yes ☐ No

Have you noticed any mouth odors or bad tastes? ☐ Yes ☐ No
Do you frequently get cold sores, blisters or any other oral lesions? ☐ Yes ☐ No
Do your gums bleed or hurt? ☐ Yes ☐ No
Have your parents experienced gum disease or tooth loss? ☐ Yes ☐ No
Have you noticed any loose teeth or change in your bite? ☐ Yes ☐ No
Does food tend to become caught in between your teeth? ☐ Yes ☐ No
If yes, where? _____
Do you gag easily? ☐ Yes ☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No If yes, please describe _____

_____

How do you feel about the appearance of your teeth? _____

Is there anything else about having dental treatment that you would like us to now? ☐ Yes ☐ No

If yes, please describe _____ _____

Patient Name

MEDICAL HISTORY

Today's Date _____ Date of Birth: _____

Physician's Name: _____ Date of last physical: _____

Preferred Pharmacy _____ Phone: _____

In case of emergency, who should be notified? _____ Phone: _____

Have you ever had any of the following? (Check all that apply)

☐ Anemia or Hemophilia	☐ Chemical Dependency	☐ Headaches	☐ Liver Disease	☐ Swelling of Ankles
☐ Arthritis/Rheumatism	☐ Chest Pain (Angina)	☐ Hearing Impaired	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Artificial Heart Valve	☐ Circulatory Problems	☐ Heart Condition	☐ Lung Disease	☐ Tobacco/Vapor Use
☐ Artificial Joints	☐ Cortisone Medication	☐ Heart Disease/Attack	☐ Mitral Valve Prolapse	☐ Transplant
☐ Asthma	☐ Diabetes	☐ Heart Murmur	☐ Osteoporosis	☐ Tuberculosis (TB)
☐ Back Problems	☐ Emphysema	☐ Heart Surgery	☐ Pacemaker/Defibrillator	☐ Vision Impaired
☐ Blood Disorders	☐ Epilepsy/Seizures	☐ Hepatitis A (Infectious)	☐ Psychiatric Care	☐ Yellow Jaundice
☐ Blood Thinners	☐ Excessive Bleeding	☐ Hepatitis B (Serum)	☐ Rheumatic Fever	
☐ Blood Transfusion	☐ Fainting or Dizzy Spells	☐ High Blood Pressure	☐ Sinus Problems/Hay Fever	
☐ Bruise Easily	☐ General Allergies	☐ HIV Positive/AIDS	☐ Shortness of Breath	
☐ Cancer	☐ Glaucoma	☐ Kidney Trouble	☐ Stroke	

Do you have any diseases, conditions or problems not listed above? ☐ Yes ☐ No If yes, please explain: _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication? ☐ Yes ☐ No
If yes, please list: _____

Do you have any general allergies? (metals, etc.) ☐ Yes ☐ No If yes, please explain: _____

Have you ever had complications or illness following dental treatment? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a reaction to local anesthetic? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, dietary supplements or herbal supplements at this time? ☐ Yes ☐ No If yes, please list: _____

Do you regularly take any of the following?
☐ Diet or Energy Supplements ☐ Echinacea ☐ Garlic ☐ Ginkgo ☐ CBD Oil ☐ Kava ☐ John's Wort ☐ Valerian ☐ Vitamin E >400 I.U.
☐ Fish Oil >3 grams/day

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No If yes, please explain: _____

Do you have any artificial joints? (i.e.: knee replacement)? ☐ Yes ☐ No If yes, please explain: _____

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what conditions: _____

(Women) Do you suspect that you may be pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

OFFICE USE ONLY

Date	Description	Date	Description

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, Date of Birth _____,
(Patient Name)

request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, Diagnosis (es), test results, date of services.

- Sensitive Protected Health Information
- You may disclose information to my family members and/or non-family members

Please list the name, phone number, and relationship

NAME	PHONE NUMBER	RELATIONSHIP

- You may leave Protected Health Information on my answering machine/voicemail:
  Phone Number _____
- You may leave me a text message: Text Phone Number _____
- You may email me (unencrypted) for dental appointments:
  Email Address _____
- You may fax me for dental information: Fax Number _____
- Other _____

*I would like to receive a copy of this office's Notice of Privacy Practices. ☐ Yes ☐ No

Print Name: _____

Signature: _____ Date: _____
(Patient's Signature (or Guardian, if Minor)

FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

_____	_____
Staff Initials	Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

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

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on 1/01/2024 and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for our treatment.

Healthcare Operations: We may use and disclose your PHI 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, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. 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 obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI 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. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. 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 the additional requests. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer: Stephanie Gonzales
Address: Rose Dental - 2731 S Rose Ave #101, Oxnard, CA 93033
Telephone: (805) 483-3658

Email: info@OxnardRoseDental.com