New patient Registration and History DATE ________________

Clara Mora, DDS
2780 State St., Suite 11
Santa Barbara, CA 93101, 805-687-4747

Single _____
Married _____
Widowed _____
Divorced _____
Separated _____

Patient's Name ________________________________

Name of Spouse ________________________________

If Child, Parent/Guardian's Name ________________________________

Street Address ________________________________ Phone ________________

City ________________ State ________________ Zip ________________

email: ________________________________ Cell ________________

Mailing address (if different) ________________________________

City ________________ State ________________ Zip ________________

Patient Employed by ________________________________ Phone ________________

Business Address ________________________________

Present Position ________________ How long held ________________

Spouse Employed By ________________________________ Phone ________________

Business Address ________________________________

Present Position ________________ How long held ________________

Purpose of this appointment ________________________________

In case of Emergency, who should be notified ________________ Phone: ________________

Responsible Party ________________________________

Patient's Social Security Number ________________ Birthday ________________

Spouse's Social Security Number ________________ Birthday ________________

If using charge card, Name ________________ Card No ________________ Exp: ________

Drivers License. No. ________________ County ________________

Do you have insurance that may cover any part of our professional services YES / NO

If so, name of primary insurance company ________________________________

Social security number of policy holder ________________ Group No. ________________

Secondary insurance company ________________________________

Social security number of policy holder ________________ Group No. ________________

Who may we thank for referring you ________________________________

Comments ________________________________

____

____

Please complete reverse side

HEALTH HISTORY

Name ____ Date ______________________________

Date of last health care exam: ________________What was this exam for?__________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:____

Are you currently receiving care? No Yes If yes, nature of care: __________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____
4. ____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

7. ______________________________ 8. ______________________________

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
Have you ever received a diagnosis of "high blood pressure"?
What is your normal blood pressure? S /D Today: ____________/________

Are you allergic or have you had a reaction to:

a. Local anesthetics ………………………………………………………... No Yes
b. Penicillin or other antibiotics …………………………………………… No Yes
c. Aspirin, Ibuprofen or Tylenol …..……………………………………… No Yes
d. Codeine, Valium® or other sedatives…………………………………… No Yes
e. Latex or Metals
f. Other (please specify)______________________________

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none* *slight* *moderate* *high*			

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

____

____

Significant findings from questionnaire or oral interview:

____

____

Dental management considerations:

____

____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name) *Patient Signature* *Date*

Doctor (Print Name) *Doctor Signature* *Date*

HIPAA Information

The health insurance Portability and Accountability Act of 1996 (HIPAA) provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. Additional information is available by calling the U.S. Department of Health and Human Services or at: www.hhs.gov

For this reason, our practice has adopted the following policies:

1- Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are Ortiz handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, as is necessary and appropriate for your care. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information, which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc… The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

2-It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

3-The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentiality rules of HIPAA.

4-The patient understands and agrees to inspections of the office and the review of documents, which may include PHI by government agencies of insurance companies in the normal performance of their duties.

5-The patient agrees to bring any concern or complaints regarding privacy to the attention of the Doctor or Office manager.

6-Your confidential information will not be used for purposes of advertising or marketing of products, goods or services. Such prohibition does not include treatment/product samples or goods of nominal value.

7-The practice agrees to provide the patient with access to their records in accordance with state law.

8-The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9-You have the right to request restrictions in the use of our protected health information and to request changes in certain policies used within the office concerning you PHI. However, the practice is under no obligation to alter internal policies to conform to your request.

10-There is no patient right to litigation under HIPAA.

HIPAA Consent & Acknowledgment Form

I, ____ do hereby Consent and Acknowledge my
(Patient's or Guardian's Name)
agreement to the terms set forth in the "HIPAA INFORMATION FORM' and any subsequent changes in office policy. I understand that this consent and acknowledgment shall remain in force indefinitely.

Signature:______________________________________ Date:_________________________