ROBERT DON
DENTISTRY

Patient Registration Form

PATIENT INFORMATION

Date		
SS#		
Last Name		
First Name	Middle Initial	
Address		
City	State	Zip
Email		
Sex ☐ Male ☐ Female	Birth Date	Age
Status ☐ Married ☐ Single ☐ Widowed ☐ Minor ☐ Separated ☐ Divorced ☐ Partners for _____ years		
Patient Employer		
Occupation		
Employer Address		
City	State	Zip
Employer Phone		
Spouse's Name		
Spouse's Birth Date		
Spouse's SS#		
Spouse's Employer		
Whom may we thank for referring you?		

DENTAL INSURANCE

Who is responsible for this account? (Subscriber's Name)		Insurance #1
Relationship to Patient		
Insurance Co.		
Group #		
Birth Date	SS#	
Is patient covered by additional insurance? ☐ Yes ☐ No		
If Yes, please complete Insurance #2 (Subscriber's Name)		Insurance #2
Relationship to Patient		
Insurance Co.		
Group #		
Birth Date	SS#	

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents have insurance coverage with ___________ _________________ and assign directly to Dr. Robert Don (Jamboree Dental) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist 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 payments for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient or Parent	
Please Print Name of Patient or Parent	
Date	Relationship to Patient

PHONE NUMBERS

Home	Work	Ext
Cell	Best time and place to call	
Spouse's Cell	Spouse's Work	Ext
In Case of Emergency, Contact Name	Relationship	
Cell	Work or Home	

DENTAL BACKGROUND

Reason for today's visit		
Former Dentist	City	State
Date of last dental visit	Date of last dental x-rays	

Robert S. Don, D.D.S.
tel 949-222-0296

Patient Health History Form

DENTAL HISTORY Please mark “Yes” or “No” to indicate if you have any of the following:

Bad breath	☐Yes ☐No	Fingernail biting	☐Yes ☐No	Loose teeth or broken filings	☐Yes ☐No	Sensitivity to heat	☐Yes ☐No
Bleeding gums	☐Yes ☐No	Food collect between teeth	☐Yes ☐No	Mouth breathing	☐Yes ☐No	Sensitivity to sweets	☐Yes ☐No
Blisters on lips or mouth	☐Yes ☐No	Foreign objects	☐Yes ☐No	Mouth pain, brushing	☐Yes ☐No	Sensitivity when biting	☐Yes ☐No
Burning sensation on tongue	☐Yes ☐No	Grinding teeth	☐Yes ☐No	Orthodontic treatment	☐Yes ☐No	Sores or growths in mouth	☐Yes ☐No
Chew on one side of mouth	☐Yes ☐No	Gums swollen or tender	☐Yes ☐No	Pain around ear	☐Yes ☐No		
Cigarette/pipe/cigar smoking	☐Yes ☐No	Jaw pain and tiredness	☐Yes ☐No	Periodontal treatment	☐Yes ☐No	How often do you floss?	____________
Dry mouth	☐Yes ☐No	Lip or cheek biting	☐Yes ☐No	Sensitivity to cold	☐Yes ☐No	How often do you brush?	____________

HEALTH HISTORY Please mark “Yes” or “No” to the following questions:

1. Are you experiencing pain or discomfort? ☐Yes ☐No
2. Are you in good health? ☐Yes ☐No
3. Has there been a change in your general health within the past year? ☐Yes ☐No If so, what? ______________________________
4. Are you under the care of a physician? If so, what condition is being treated? ☐Yes ☐No
5. Have you been hospitalized or had a serious operation or illness within the last 5 years? ☐Yes ☐No
6. Do you have or have you had any of the following diseases or problems? Please check all that apply:

Heart Problems	☐Yes ☐No	AIDS or HIV	☐Yes ☐No	Tuberculosis	☐Yes ☐No	Cancer	☐Yes ☐No
Heart Attack	☐Yes ☐No	Anemia	☐Yes ☐No	Ulcers	☐Yes ☐No	Chemical Dependency	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Bleeding Problems	☐Yes ☐No	Jaundice (yellow skin/eyes)	☐Yes ☐No	Chemotherapy	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Blood Transfusion	☐Yes ☐No	Artificial Joint	☐Yes ☐No	Cortisone Treatments	☐Yes ☐No
Stroke	☐Yes ☐No	Blood Disease	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No	Cough, persistent or bloody	☐Yes ☐No
Heart Pacemaker	☐Yes ☐No	Circulatory Problems	☐Yes ☐No	Scarlet Fever	☐Yes ☐No	Fainting or Dizziness	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Tumor/Growth Head/Neck	☐Yes ☐No	Back Problems	☐Yes ☐No	Headaches	☐Yes ☐No
Congenital Heart Lesions	☐Yes ☐No	Radiation Treatment	☐Yes ☐No	Diabetes (sugar in blood)	☐Yes ☐No	Jaw Pain	☐Yes ☐No
Pacemaker	☐Yes ☐No	Arthritis, Rheumatism	☐Yes ☐No	Venereal Disease	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No
Shortness of Breath	☐Yes ☐No	Asthma	☐Yes ☐No	Epilepsy	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Sinus Trouble	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Emphysema	☐Yes ☐No	Nervous Problems	☐Yes ☐No
Skin Rash	☐Yes ☐No	Liver Disease	☐Yes ☐No	Swollen Feet or Ankles	☐Yes ☐No	Psychiatric Care	☐Yes ☐No
Special Diet	☐Yes ☐No	Respiratory Disease	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No	Bleeding Abnormally, with extractions or surgery	☐Yes ☐No
Hepatitis Type ____	☐Yes ☐No	Glaucoma	☐Yes ☐No	Thyroid Problems	☐Yes ☐No		
Herpes	☐Yes ☐No	Weight Loss, unexplained	☐Yes ☐No	Tonsillitis	☐Yes ☐No		

MEDICATIONS Please mark “Yes” or “No” for the following:

1. Have you ever taken “fen-phen” or anything like it (Ionimin, Adipex, Fastin [phentermine]) etc.? ☐Yes ☐No
2. Are you taking any drugs, medicine or diet pills? ☐Yes ☐No
3. Are you allergic or have you reacted adversely to any drugs/medicines? ☐Yes ☐No

If yes, what drug(s) and/or medicines: ______________________________

Please indicate any others which apply: ______________________________

List any medications you are currently taking and the correlating diagnosis:

Med: ____________________ Diagnosis: ________________________

Med: ____________________ Diagnosis: ________________________

Pharmacy Name: ___________ Phone: ________________________

WOMEN Please answer the following:

Are you taking birth control pills? ☐Yes ☐No
Are you nursing? ☐Yes ☐No
Are you pregnant? ☐Yes ☐No

What is your due date? ______________

EYES

Do you wear contact lenses? ☐Yes ☐No

ALLERGIES Are you allergic to any of the following:

☐ Aspirin	☐ Local Anesthetic	☐ Percodan
☐ Barbiturates (Sleeping Pills)	☐ Nembutal/Seconal	☐ Erythromycin
☐ Codeine	☐ Nitrous Oxide	☐ Scopolamine
☐ Iodine	☐ Novocain / Xylocaine	☐ Tetracycline
☐ Latex	☐ Penicillin	☐ Valium

Robert S. Don, D.D.S.
tel 949-222-0296

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please read and review it carefully.

At Robert S. Don, D.D.S. office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow terms on this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send recall cards or other appointment reminders. We may also call you and leave a message on your machine to remind you about your upcoming dental appointment or leave a message with whom ever answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your healthcare when required by law.

If this practice is sold, your information will become property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any of the uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or phone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a fee for the copies. There will be a $30.00 duplicating fee.

You have the right to request an amendment or change to your health information. Give us your request for changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509 F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information, please contact our privacy officer/receptionist at 949-222-0296.

Acknowledgement: I have received a copy of Robert S. Don, D.D.S Notice of Privacy Practices.

Signed ______________________________

Print Name ______________________________

Date ______________________________

If signing as a parent or guardian, please note the name of the patient ____________________

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Appointment Guidelines and Courtesy Agreement

We, at Robert Don Dentistry, are committed to providing a pleasant dental experience for you and your family. A major focus of our practice is seeing patients in a timely manner and being punctual with respect to your schedule. We would like to clarify our appointment guidelines and ask that you assist us in this endeavor.

There will be absolutely no charge for your need to reschedule an appointment provided you give us 24-48 hours notice and that you contact us during business hours. This would allow us the opportunity to give this time to another patient who is in need and waiting.

Last minute cancellation can cause hardships for many individuals. It is our sincere hope that you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice. Thank you.

Acknowledgement
I have received a copy of Robert S. Don, D.D.S Notice of Appointment Guidelines.

Signed ______________________________

Print Name ______________________________

Date ______________________________

Cancellations without 24-48 hour notice will incur a $65.00 charge for each appointment cancelled or broken.