Dr. Kent E. Davis
5100 Clayton Road Ste A19, Concord, CA 94521
T. (925) 825-1130
www.drkentdavis.com drkentdavis@aol.com

A VERY WARM WELCOME TO YOU!

My team and I would like to thank you for selecting our office to care for your dental needs. Our goal is to provide each patient with the highest quality dental care in a gentle, efficient and pleasant manner and to strongly encourage prevention of future dental problems.

Your first visit will be spent conducting a thorough clinical examination which combines your medical history with your dental needs. We will be taking the necessary radiographs to detect decay and to determinate the condition of the supporting bone and screen for all oral cancer.

Please complete our new patient registration and medical history forms.

Please do not forget to bring these forms to your first visit!

Also for your information **only** is a copy of our Notice of Privacy Practices that federal law requires all health care providers to give to patient.

If you have any questions, please, do not hesitate to call our office at 925-825-1130 or e-mail us at drkentdavis@aol.com. We look forward to meeting you.

Sincerely,

Dr. Kent Davis and Team

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NEW PATIENT REGISTRATION

Patient information is confidential and necessary for our files and your HEALTH

Patient:

How did you find our office? [ ]

What do you prefer to be called? [ ] Union ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Last Name First Name Mid Sex Age Birth

Address City State Zip

Res. Phone Bus. Phone Ext Fax Cell. Phone

email Driver's License SSN

Employed By Present Position/Occupation How Long Held (years)

Employer's Address City State Zip Code

Spouse's Name Occupation How Long Held (years)

Employed By Bus. Phone Ext Fax

Person responsible for account/relation Res. Phone Bus. Phone Ext

Address City State Zip Code

PRIMARY DENTAL INSURANCE Name of Insured SSN Date of Birth

Name of Insurance Co. Billing Address

State Zip Code Phone Group # City

SECONDARY DENTAL INSURANCE Name of Insured SSN Date of Birth

Name of Insurance Co. Billing Address City

State Zip Code Phone Group #

WHOM MAY WE THANK FOR REFERRING YOU? Name Address

Physician or Clinic ☐ None Patient Initial

Name

Address

City State Zip Code

Previous Dentist ☐ None Patient Initial

Name

Address

City State Zip Code

Someone to notify in case of Emergency not living with you Name Phone

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of patient's dental needs. I also authorize Doctor to perform any and all form of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risk including temporary or permanent numbness. I understand that responsibility for payment for Dental Services provided in this Office for myself or my dependents is mine due and payable at time services are rendered. I further understand that a 1.8% finance charge (22% annually) will be added to my balance over 30 days. In the event default I (we) promise to pay legal interest on the indebtedness together with such collection cost and reasonable attorney fees as may be required to effect collection of this note. **I also understand that if I miss or break an appointment without 48 hours notice to the Doctor, I will be charged $ 55.00 per hour missed. I also assign all insurance benefits to the Doctor.**

Patient Signature (parent of Child) ____________________ Date ____________

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MEDICAL & DENTAL HISTORY

This Medical History is confidential and necessary for our files and your Health!

What conditions are you concerned about? ☐

I. Select each appropriate answer (leave blank if you do not understand the question).

Reason for seeking dental treatment ☐ Check Up/Exam ☐ Cleaning ☐ Evaluation ☐ Consultation/2nd Opinion

☐ Yes ☐ No Is your general health good? If no explain why

Date of Last Medical Exam

Date of Last Dental; Exam

☐ Yes ☐ No Has there been a change in your health within the last year?

☐ Yes ☐ No Are you being treated by a physician now? if Yes What?

☐ Yes ☐ No Have you been hospitalized or had a serious illness in the last three years? If Yes Why?

II. Have you Experienced:

☐ Yes ☐ No Chest pain (Angina)?

☐ Yes ☐ No Shortness of Breath?

☐ Yes ☐ No Recent weight loss, fever, night sweats?

☐ Yes ☐ No Persistent cough, coughing up blood?

☐ Yes ☐ No Bleeding problems, bruising easily?

☐ Yes ☐ No Sinus problems?

☐ Yes ☐ No Difficulty swallowing?

☐ Yes ☐ No Frequent vomiting or eating disorder?

☐ Yes ☐ No Difficulty urinating, blood in urine?

☐ Yes ☐ No Metal Allergies (irritation from Jewelry?

☐ Yes ☐ No Fainting spells/dizziness?

☐ Yes ☐ No Latex allergy?

☐ Yes ☐ No Dry mouth

☐ Yes ☐ No Joint pain, TMJ syndrome?

III. Do you have or have you had:

☐ Yes ☐ No Heart murmur?

☐ Yes ☐ No Heart disease? Heart attack/Date

☐ Yes ☐ No Heart defects?

☐ Yes ☐ No Rheumatic fever?

☐ Yes ☐ No Blood disorders (sicle cell/hemophilla?)

☐ Yes ☐ No Stroke, hardening of arteries? Date

☐ Yes ☐ No High blood pressure?

☐ Yes ☐ No Cold sores or fever blisters?

☐ Yes ☐ No TB emphysema, other lung diseases?

☐ Yes ☐ No Herpes?

☐ Yes ☐ No Hepatitis A or B, other liver diseases?

☐ Yes ☐ No **Allergies** (to medication. food environmental)? List

☐ Yes ☐ No Family history of diabetes, heart problems?

☐ Yes ☐ No HIV/AIDS?

☐ Yes ☐ No Tumors, Cancer?

☐ Yes ☐ No Arthritis? Rheumatism?

☐ Yes ☐ No Thyroid , adrenal diseases?

☐ Yes ☐ No Diabetes?

☐ Yes ☐ No Problems with alcohol or drugs

IV. Do you have or have you had:

☐ Yes	☐ No	Artificial joints/pins/screws - When?	☐ Yes	☐ No	Chemotherapy?
☐ Yes	☐ No	Blood Transfusions?	☐ Yes	☐ No	Pacemaker?
☐ Yes	☐ No	Prosthetic heart valve?	☐ Yes	☐ No	Contact Lenses?
☐ Yes	☐ No	Psychiatric care?	☐ Yes	☐ No	Recreational drugs?
☐ Yes	☐ No	Radiation Treatments?	☐ Yes	☐ No	Tobacco in any form?

V. Are you taking:

☐ Yes ☐ No **Drugs, Medications** (including aspirin and any over the counter medications or remedies including osteoporosis ?

VI. Women Only:

☐ Yes ☐ No Are you (or could you be) Pregnant?

☐ Yes ☐ No Are you taking birth control pills? if yes name

VII. All Patients:

☐ Yes ☐ No Do you have or had any other diseases or medical problems NOT listed on this form (Ex: Alzheimer's ?

To the best of my knowledge I have answered every question on this form completely and accurately. I will inform my dentist of any change in my health and /or medication.

PATIENT SIGNATURE: X ______________________ DATE:

PRINT NAME: ______________________ DENTIST SIGNATURE ______________________

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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 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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect today (updated 1/ 2011), 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 provide the new Notice at our practice location, and we will distribute it 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.**Your Authorization:** In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.
Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.
To You or Your Personal Representative: 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 your personal representative, 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 health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in 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 forms of health information.
Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.
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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.
Decedents: We may disclose health information about a decedent as authorized or required by law.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal 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 the protected health information of an 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).
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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $1.00 for each page, $9.00 per hour for staff time to copy your health information, 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, health care 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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 of 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.

Contact Officer: Kent E. Davis
Address: 5100 Clayton Road, Street Suite A19 Concord, CA 94521
Telephone: 925-825-1130 **E-mail:** drkentdavis@aol.com

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; January 30, 2009

☐ I have read and acknowledge receipt of the above Notice of Privacy Pratices

You may refuse to sign this acknowledgement.

Date

PATIENT SIGNATURE: X ______________________

PRINT NAME: ______________________

I have received a copy of this office's Notice of Privacy Practices.

For Office Use Only

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

☐ Individual refused to sign
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Communications barriers prohibited obtaining the acknowledgement
☐ Other

Print Form | Reset Form