Please complete the following confidential patient registration form and dental history:

Responsible Party Information:

Last Name_____First Name_____Middle Initial_____

Address_____City_____State_____

Zip Code_____

Home Phone ( )_____Work( )_____Cell ( )_____

Date of Birth_____Age_____Marital Status_____

Patient (If other than Responsible Party):

Last Name_____First Name_____Middle Initial_____

Address_____City_____State_____

Zip Code_____

Home Phone ( )_____Work ( )_____Cell ( )_____

Date of Birth_____Age_____Marital Status_____

Whom May We Thank For Referring You? _____

Preferred Pharmacy _____ Phone #_____

Email Address_____

Current Physician or Medical Doctor_____

Phone # _____

Children or Family Members Currently in Our Practice:

_____

_____

Dental History

Patient Name:_____ Date:_____

- □ Yes □ No **Do your gums bleed while brushing or flossing?**
- □ Yes □ No **Are your teeth sensitive to hot or cold liquids/foods?**
- □ Yes □ No **Are your teeth sensitive to sweet or sour liquids/foods?**
- □ Yes □ No **Do you have discomfort with your teeth?**
- □ Yes □ No **Do you have lumps in or near your mouth?**
- □ Yes □ No **Have you had any neck, head, or jaw injuries?**
- □ Yes □ No **Have you ever experienced any of these problems in your jaw?**
  □Clicking □Discomfort (joint, ear, side of face) □ Difficulty Opening or Closing
  □ Difficulty Chewing □ Bite does not feel right
- □ Yes □ No **Do you have frequent headaches?**
- □ Yes □ No **Do you clench or grind your teeth?**
- □ Yes □ No **Have you ever had a difficult extraction in the past?**
- □ Yes □ No **Have you ever had prolonged bleeding following an extraction?**
- □ Yes □ No **Have you had orthodontic treatment?**
- □ Yes □ No **Do you get cold sores or fever blisters, or herpes lesions?**
- □ Yes □ No **Do you consider yourself a nervous dental patient?**
- □ Yes □ No **Have you ever needed sedation for dental treatment?**
- □ Yes □ No **Have you ever received oral hygiene instructions regarding the care of your teeth & gums?**
- □ Yes □ No **Have you ever had periodontal (gum) treatments or deep scalings (cleanings)?**
- □ Yes □ No **Do you like your smile (color, shape, appearance of your teeth)?**
- □ Yes □ No **Do you feel that your teeth don't fit together well when you bite?**
- □ Yes □ No **Do you feel like you have bad breath often?**
- □ Yes □ No **Do you feel that your teeth have shifted or moved?**
- □ Yes □ No **Are you interested in cosmetic dentistry?**

□ Yes □ No **If you have missing teeth, would you be interested in knowing more about implant options?**

□ Yes □ No **Have you ever had a reaction to local anesthesia (Novocain)?**

FOR DENTURE AND PARTIAL WEARERS

How long have you worn dentures/partials?_____
How many sets of partials/dentures have you had throughout your life? _____

- □ Yes □ No **Are your dentures/partials comfortable?**
- □ Yes □ No **Do you use denture adhesives or pastes to help secure your dentures/partials?**
- □ Yes □ No **Do you avoid certain foods?**
- □ Yes □ No **Does your denture/partial move, slip or feel loose when you talk, eat, laugh, yawn or sneeze?**
- □ Yes □ No **Do you feel your dentures/partials have decreased the flavor of foods you eat or reduced your thermal sensations?**
- □ Yes □ No **Do you have a hard time cleaning your dentures/ partials, or remaining teeth?**

Any Additional Concerns You Would Like To Discuss With Dr. Correa:

_____
_____
_____

Patient Signature:_____ Date:_____

Medical History

Although dental personnel primarily treat the areas in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or the medications and vitamin and herbal supplements you take, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

PATIENT NAME:_____

Are you under a physician's care now? **□ Yes □ No □ N/A**_____
If yes, please explain:_____

Have you ever been hospitalized or had a major operation? **□ Yes □ No □ N/A**_____
If yes, please explain:_____

Have you ever had a serious head or neck injury? **□ Yes □ No □ N/A**_____

Do you take, or have you taken, Phen Phen, or Redux? **□ Yes □ No □ N/A**_____

Do you take, or have you taken any medications for Osteoporosis? **□ Yes □ No □ N/A** _____

Do you use tobacco? **□ Yes □ No □ N/A**_____

Are you on a special diet? **□ Yes □ No □ N/A**_____

Do you use controlled substances? **□ Yes □ No □ N/A**_____

Are you taking any anticoagulants, blood thinners or aspirin? **□ Yes □ No □ N/A**_____

Are you taking any medications, drugs or vitamins? **□ Yes □ No □ N/A**_____

Please list all medications including non-prescription medications, vitamins, minerals or herbs.
_____
_____
_____

Check any of the following that you are taking or have taken:

□Cortisone Drugs □ Blood Thinners
□Steroids □ Sedatives □ MAO Inhibitors □ Tranquilizers
□ Anti-depressants □ Osteoporosis Medications □ Aspirin Daily

Check any of the following that you are ALLERGIC to:

□ Penicillin □ Amoxicillin □ Other Antibiotics _____
□ Barbituates (Codeine) □ Sedatives □ Iodine □ Latex Rubber
□ Any metals (i.e. nickel, mercury, etc.) □ Aspirin □ Local Anesthetics
□ Allergies to other substances:_____

N/A Indicates Not Answered by Patient

Medical History *Continued from previous page.*

PATIENT NAME:_____

Do you have, or have you had any of the following:

□ Aids/Hiv Positive	□ Chest Pains	□ Frequent headaches	□ Irregular Heartbeat	□ Scarlet Fever
□ Alzheimer's	□ Cold Sores	□ Herpes Virus	□ Kidney Problems	□ Shingles
□ Anaphylaxis	□ Glaucoma	□ Congenital Heart Disorder	□ Leukemia	□ Sickle Cell Disease
□ Anemia	□ Convulsions	□ Hay Fever	□ Liver Disease	□ Sinus Trouble
□ Angina	□ Heart Attack	□ Cortisone Medication	□ Low Blood Pressure	□ Spina Bifida
□ Arthritis/Gout	□ Diabetes	□ Heart Murmur*	□ Lung Disease	□ Stomach Disease
□ Drug Addiction	□ Stroke	□ Artificial Heart Valve*	□ Heart Pace Maker*	□ Artificial Joint *
□ Easily Winded	□ Heart Disease	□ Mitral Valve Prolapse *	□ Pain in Jaw Joints	□ Swelling of Limbs
□ Asthma	□ Emphysema	□ Hemophilia	□ Parathyroid Disease	□ Thyroid Disease
□ Blood Disease	□ Hepatitis A	□ Epilepsy or Seizures	□ Psychiatric Care	□ Tonsillitis
□ Blood Transfusion	□ Hepatitis B or C	□ Excessive Bleeding	□ Radiation Treatments	□ Tuberculosis
□ Fever Blisters	□ Excessive Thirst	□ Breathing Problems	□ Recent Weight Loss	□ Tumors/Growths
□ Bruise Easily	□ Ulcers	□ Fainting Spells/Dizziness	□ High Blood Pressure	□ Renal Dialysis
□ Cancer	□ Frequent Cough	□ Hives/Rash	□ Rheumatic Fever*	□ Venereal Disease
□ Chemotherapy	□ Hypoglycemia	□ Rheumatism	□ Frequent Diarrhea	□ Yellow Jaundice
□ Any Auto Immune Disorders				

Have you had any serious illness not listed above: □ Yes □ No □ N/A (Please comment below):

_____

_____

_____

***Condition may require medication prior to treatment**

WOMEN ONLY:

Are you pregnant or trying to get pregnant?	**□ Yes**	**□ No**	**□ N/A**
Are you nursing?	**□ Yes**	**□ No**	**□ N/A**
Are you taking oral contraceptives?	**□ Yes**	**□ No**	**□ N/A**
Are you taking estrogen therapy?	**□ Yes**	**□ No**	**□ N/A**

This is to certify that I, the undersigned, mutually agree to the necessary or advised treatment, including the use of local anesthetics as indicated. Furthermore, I grant permission to any and all health care providers or legal counsel to release my current name, address, phone number and any treatment notes to Dr. Correa or a member of his staff in the event I should I change any of the answers on this medical history. My signature on this form indicates that I have read and understand the above information and that the above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I also understand that any changes to this medical history must be given to Dr. Correa in writing.

Patient Signature:_____ **Date:** _____

Responsible Party if patient is a minor or dependant:_____

INSURANCE INFORMATION

Primary Carrier Only

Policy Holder Name:_____ Date of Birth:_____

Social Security #_____

Employer Name and
Address:_____
_____

Employer Phone #_____

Insurance Carrier Name:_____

Insurance Carrier Address:_____
_____

Insurance Carrier Phone #:_____

Group or Policy #_____

Other Patients Covered Under This Insurance Plan:

Patient Names and Dates of Birth:_____
_____
_____

Please Review and sign below:

To avoid misunderstandings regarding dental insurance we wish our patients to know that all professional services are rendered and charged directly to the patient and that the patient is personally responsible for payment of our fees. We will prepare the necessary forms to help you obtain benefits from your insurance carrier, but we do not guarantee that they will actually pay the amount estimated in your financial arrangement.

I hereby authorize Dr. Correa to release any information (x-rays, documentation, etc.) to my insurance carrier as necessary to obtain dental benefits and authorize the use of my social security # to file my claim. I authorize payment of dental benefits otherwise payable to me directly to the office of Dr. James Correa. I understand that if my account balance becomes 60 days past due that I am fully responsible for the balance due. If my balance becomes 90 days past due, my account will be considered delinquent and credit bureaus will be contacted.

_____ _____
Signature Print Name

Date:_____

NOTICE OF PRIVACY PRACTICES
DR. JAMES CORREA

Office Contact: James Correa
Effective date of notice: April 25, 2003

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND HOW YOU CAN ACCESS THIS INFORMATION.

We require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to the inspection and the copying of your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, and requesting that we restrict certain uses and disclosures of your rights.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under law. We may revise our Notice form from time to time. The effective date at the top of this page indicates the date of the most current Notice in effect. You have a right to receive a copy of our most current Notice in effect. If you would like to receive a detailed Notice of Privacy Practices please request a copy at the front desk.

If you have any questions, concerns, or complaints about the Notice or your medical information, please contact Dr. Correa at 949-706-2100

_____ _____
Signature Date

_____
Relationship to Patient