PATIENT REGISTRATION

First Name:_____Last Name:_____Middle Initial:_____
Preferred Name:_____
If minor, parent's names:_____
In case of emergency, who should be notified_____Phone_____
Whom may we thank for referring you: _____(circle) Family Friend Internet Work
Patient is (circle one or both): Policy Holder/Responsible Party

Patient Information Sex (circle): Male or Female
Address:_____ City:_____State:_____Zip:_____
Person responsible for your account:_____Phone:_____
Please circle best way to contact you:
Home Phone:_____Cell Phone:_____
E-Mail:_____ Drivers License:_____
Birth Date:_____ Age:_____ Social Security #:_____
Name of your Pharmacy:_____ Phone_____
Patient Employed By:_____Phone:_____Ext:_____
Employment Status (circle): Full Time Part Time Retired Unemployed
Student (circle): Full Time Part Time Not a Student

Marital Status (circle): Married Single Divorced Separated Widowed
Spouse Name_____Phone_____
Spouse Employed by_____Phone_____
Spouse Social Security #_____

Responsible Party Information
Name and Relationship to Patient:_____
Address:_____ City:_____State:_____Zip:_____
Birth Date:_____Age:_____ Social Security_____ DriversLicense:_____
Home Phone:_____Cell Phone:_____Work Phone:_____Ext:_____

Primary Insurance Information
Name of Insured:_____ Relationship to Insured (circle): Self Spouse Child Other
ID Number_____ Group Number_____
Insured Social Security #_____ Insured Birth Date:_____

Employer:_____	**Insurance Company**:_____
Address:_____	Address:_____
City:_____State_____Zip_____	City:_____State_____Zip_____

Secondary Insurance Information
Name of Insured:_____ Relationship to Insured (circle): Self Spouse Child Other
ID Number_____ Group Number_____
Insured Social Security #_____ Insured Birth Date:_____

Employer:_____	**Insurance Company**:_____
Address:_____	Address:_____
City:_____State:_____Zip:_____	City:_____State:_____Zip:_____

I understand that I am responsible for all fees and services rendered. I understand that I am responsible for ALL fees regardless of insurance coverage, unless payment agreement is made. I also understand that interest will be charged to my account of 1.5% monthly if more than 30 days overdue, unless a prior payment agreement has been made. As a parent I understand I am responsible for my child's account.

Patient's Signature_____Date_____
(Parent's Signature If Minor)

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name _____ Birthdate _____ Age _____

Why are you now seeking dental treatment? _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
3. Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain _____		
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
5. (Women) Are you pregnant? If so, give due date _____	☐	☐
6. Do you use tobacco in any form? If yes, how much _____	☐	☐
7. Do you use alcoholic beverages (more than 2 drinks per day)?	☐	☐

8. Do you have or have you ever had any of the following?

GENERAL	YES	NO
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
Other _____		

HEART/BLOOD VESSELS	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other _____		
BONE/MUSCLES		
Arthritis/rheumatism	☐	☐
Artificial joints	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
Black, bloody or pale stools	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
Radiation therapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
AIDS	☐	☐

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Please complete reverse side

9. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO
Local anesthetics (e.g. novocaine)	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐
Penicillin/other antibiotics	☐	☐
Aspirin or codeine	☐	☐
Sulfa drugs	☐	☐

Other allergies _____

10. Are you taking any of the following?

	YES	NO
Antibiotics/sulfa drugs	☐	☐
Blood thinners	☐	☐
Blood pressure medication	☐	☐
Thyroid medicine	☐	☐
Cortisone/steroids	☐	☐
Antihistamines/allergy drugs/ cold remedies	☐	☐
Tranquilizers	☐	☐
Insulin/other diabetes drugs	☐	☐
Recreational drugs	☐	☐
Digitalis/other heart medications	☐	☐
Nitroglycerin	☐	☐
Aspirin	☐	☐

Other medication _____

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. _____
2. _____
3. _____
4. _____

11. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

_____

12. Physician's Name _____ Phone _____

13. Have you ever had any serious trouble associated with previous dental treatment? _____

_____

14. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so, when? _____

17. Do you have or have you ever had any of the following?

MOUTH

	YES	NO
Bleeding, sore gums	☐	☐
Unpleasant taste/bad breath	☐	☐
Burning tongue/lips	☐	☐
Frequent blisters, lips/mouth	☐	☐
Swelling/lumps in mouth	☐	☐
Ortho treatments (braces)	☐	☐
Biting cheeks/lips	☐	☐
Clicking/popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐

TEETH

	YES	NO
Loose teeth	☐	☐
Sensitive to hot	☐	☐
Sensitive to cold	☐	☐
Sensitive to sweets	☐	☐
Sensitive to biting	☐	☐
Food impaction	☐	☐
Clenching/grinding	☐	☐
Shifting of teeth	☐	☐
Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?	YES	NO
Brush	☐	☐
Dental floss	☐	☐
Fluoride rinse	☐	☐

Other _____

How often do you brush _____

Brush is: Soft ☐ Medium ☐ Hard ☐

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent, or Guardian _____ Date _____

Frank Navarro D.M.D., P.A.

3100 Rt. 138 Wall, NJ 07719
732-681-7400
Office contact person: Judy Castravet

3822 River Road, Suite 2 Pt. Pleasant, NJ 08742
732-295-8181
Office contact person: Debbie

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient number _____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:-

1. Detailed description of the information to be releas-ed:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

Effective date of notice_____

NOTICE OF PRIVACY PRACTICES
Frank Navarro, D.M.D. P.A.

3100 Rt 138 Wall, NJ 07719
732-681-7400
fax 732-681-3607
Office contact person: Judy Castravet

3822 River Road, Suite 2, Pt. Pleasant, NJ 08742
732-295-8181
fax 732-295-2876
Office contact person: Debbie Kolb

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or

orders of courts or administrative agencies;

- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- [specify other uses and disclosures affected by state law].]

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or

sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Frank Navarro DMD, P.A. Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____