



J A M B O R E E  
D E N T A L

62 Corporate Park, Suite 230 - Irvine, CA 92606  
tel 949-222-0296 - fax 949-222-1110 - www.dondds.com

### Patient Registration and Health History Form

#### RESPONSIBLE PARTY

FIRST NAME	INITIAL	LAST NAME		HOME PHONE		
ADDRESS		CITY			STATE	ZIP
BIRTHDATE	AGE	SOCIAL SECURITY	DRIVER'S LICENSE		STATE	
EMPLOYER	OCCUPATION	BUSINESS ADDRESS	CITY, STATE	ZIP	WORK PHONE	
NEAREST RELATIVE NOT LIVING WITH YOU	RELATIONSHIP	RELATIVE'S ADDRESS	CITY, STATE	ZIP	DAYTIME PHONE	

#### SPOUSE

FIRST NAME	INITIAL	LAST NAME		AGE	BIRTHDAY
EMPLOYER	OCCUPATION	BUSINESS ADDRESS	CITY, STATE	ZIP	WORK PHONE

#### CHILDREN

NAME	AGE	BIRTHDATE	GENDER	SCHOOL	GRADE
NAME	AGE	BIRTHDATE	GENDER	SCHOOL	GRADE
NAME	AGE	BIRTHDATE	GENDER	SCHOOL	GRADE
NAME	AGE	BIRTHDATE	GENDER	SCHOOL	GRADE

#### INSURANCE

PRIMARY INSURANCE CO.	ADDRESS	CITY	STATE	ZIP
EMPLOYEE	SOCIAL SECURITY	MEMBER NUMBER	GROUP NUMBER	
SECONDARY INSURANCE CO.	ADDRESS	CITY	STATE	ZIP
EMPLOYEE	SOCIAL SECURITY	MEMBER NUMBER	GROUP NUMBER	

Who may we thank for referring you to our office?

Person to contact in case of an emergency:

NAME

ADDRESS

PHONE

Is another family member a patient in our practice? NO YES NAME

## Robert S. Don, D.D.S Patient Registration and Health History Form

- |  |     |    |
|--|-----|----|
| 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 |
| 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 any or all which apply: |     |    |

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart trouble                | <input type="checkbox"/> Anemia            | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Heart Attack                 | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Ulcers                      |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Jaundice (yellow skin/eyes) |
| <input type="checkbox"/> Heart Murmur                 | <input type="checkbox"/> Tumor or Growth   | <input type="checkbox"/> Artificial Joint Placed     |
| <input type="checkbox"/> Rheumatic Fever              | <input type="checkbox"/> Radiation         | <input type="checkbox"/> Diabetes (sugar in blood)   |
| <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Venereal Disease            |
| <input type="checkbox"/> Heart Pacemaker              | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Epilepsy                    |
| <input type="checkbox"/> AIDS or HIV-related Disorder | <input type="checkbox"/> Kidney Disease    |  |
| <input type="checkbox"/> Hepatitis (Liver Disease)    | <input type="checkbox"/> Glaucoma          |  |

- |  |     |    |
|--|-----|----|
| 7. Are you taking any drugs, medicine or diet pills?                         | YES | NO |
| 8. Are you allergic or have you reacted adversely to any drugs or medicines? | YES | NO |

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

Please indicate any others which apply:

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Local Anesthetic     | <input type="checkbox"/> Percodan          |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Nembutal/Seconal     | <input type="checkbox"/> Other Antibiotics |
| <input type="checkbox"/> Darvon       | <input type="checkbox"/> Nitrous Oxide        | <input type="checkbox"/> Scopolamine       |
| <input type="checkbox"/> Demerol      | <input type="checkbox"/> Novocain / Xylocaine | <input type="checkbox"/> Sleeping Pills    |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin           | <input type="checkbox"/> Tetracycline      |
|                                       |   | <input type="checkbox"/> Valium            |

- |   |     |    |
|---|-----|----|
| 9. Do you smoke? If yes how much?   | YES | NO |
| 10. Have you ever had any of the following treatments? Please check any or all which apply: |     |    |

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Orthodontics  | <input type="checkbox"/> Jaw Joint Pain             |  |
| <input type="checkbox"/> Oral Surgery  | <input type="checkbox"/> Clicking of Jaw            |  |
| <input type="checkbox"/> Gum Treatment | <input type="checkbox"/> Difficulty Opening/Closing |  |
| <input type="checkbox"/> TMJ Treatment | <input type="checkbox"/> Any Injury to Jaw/Face     |  |

Notes:

- |   |     |    |
|---|-----|----|
| 11. Have you ever had a dental implant of any kind?   | YES | NO |
| 12. Have you had any serious trouble associated with any previous dental treatment?             | YES | NO |
| If yes, please explain:   |     |    |
| 13. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?     | YES | NO |
| 14. Do you have a disease, condition, or problem not listed above that you think I should know? | YES | NO |
| 15. For Women Only, Are you pregnant? If yes, what month are you due? _____                     | YES | NO |
| Are you taking birth control pills?   | YES | NO |

**CONSENT:** The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (name of patient) \_\_\_\_\_ and further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent Signature (if patient is minor) \_\_\_\_\_

## **Robert S. Don, D.D.S 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.**

# Authorization for Signature on File for Patients with Dental Insurance

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT

### Release of Information/Financial Responsibility

I, \_\_\_\_\_, hereby authorize the office of **Robert S. Don, D.D.S.**, to affix my name to any and all claims or documents as related to any and all benefits due me.

I understand and agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to insurance or healthcare claims. This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

\_\_\_\_\_  
Today's Date

✓  
\_\_\_\_\_  
Signature of Patient  
( Parent or Guardian if Minor )

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Witnessed By

**INSURED'S NAME -** \_\_\_\_\_

## INSURED

### Assignment of Benefits

I, \_\_\_\_\_, hereby authorize the office of **Robert S. Don, D.D.S.**, to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment, retirement and/or other reason(s) for benefits coverage.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the dental entity listed above. This "Signature On File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Signature of Insured ( Or Person Authorized to Sign for Insured )

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Witnessed By



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### **Robert S. Don, D.D.S 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.**

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, Laurie Y., at (949) 679-6600.

This notice goes into effect as of April 14, 2003.

**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 \_\_\_\_\_