JAMBOREE
DENTAL

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:

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

7. Are you taking any drugs, medicine or diet pills? YES NO
8. Are you allergic or have youreacted adversely to any drugs or medicines? YES NO
   If yes, what drug(s) and/or medicines:
   Please indicate any others which apply:

___ Aspirin
___ Codeine
___ Darvon
___ Demerol
___ Erythromycin
___ Local Anesthetic
___ Nembutal/Seconal
___ Nitrous Oxide
___ Novocain / Xylocaine
___ Penicillin
___ Percodan
___ Other Antibiotics
___ Scopolamine
___ Sleeping Pills
___ Tetracycline
___ 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:

___ Orthodontics
___ Oral Surgery
___ Gum Treatment
___ TMJ Treatment
___ Jaw Joint Pain
___ Clicking of Jaw
___ Difficulty Opening/Closing
___ 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 readiographs, 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 $30.00 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 out 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________________