Patient Registration Form

Parisa Kosha DDS, Inc.
Mario Marroquin DDS, Inc.
17705 Hale Ave, STE G-1, Morgan Hill, CA 95037

Email: Today's Date:

Preferred Name: ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. How did you find out about us:

Name: Last First Middle Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

Address: Mailing address City: State: Zip:

SS#: Date of Birth: Sex: M F

Employer: Business Phone: *include area code* ( )

Emergency Contact: Relationship: Home Phone: *include area code* ( ) Cell Phone: *include area code* ( )

College Student Status: ❑ Full Time ❑ Part Time Please provide school info: School Name:_____

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired Address:_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed Address 2:_____

Pref. Pharmacy: Phone: ( ) City, State, Zip:_____

Dental Insurance Information

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address of Policy Holder: _____ Address: _____

Address Line À _____ City, State, Zip:.....

City, State, Zip:_____ Ins. Company Phone #:_____

Insurance ID#:_____ **Group ID#:**_____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address of Policy Holder: _____ Address: _____

Address Line 2: _____ City, State, Zip:_____

City, State, Zip:_____ Ins. Company Phone #:_____

Insurance ID#:_____ **Group ID#:**_____

Dental Information For the following questions, mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontic (braces) treatments?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

Anxiety seeing the dentist: NONE / MILD / MODERATE / SEVERE

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Are you now under the care of a physician?	❑	❑	❑
Physician Name: _____			
Phone: *include area code* (_____) _____			
Address/City/State/Zip: _____			
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
If yes, what condition was treated? _____			
Date of last physical exam: _____			
Do you wear contact lenses?	❑	❑	❑
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or fen-phen (fenfluramine-phentermine combination)?	❑	❑	❑
Are you taking or scheduled to begin taking either of the medications alendrontate (Fosamax®) or risendronate (Actonel®) for osteoporosis or Paget's disease?	❑	❑	❑
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastic cancer?	❑	❑	❑
Date Treatment Began: _____			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	❑	❑	❑
If yes, what was the illness or problem? _____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	❑	❑	❑
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____			
Do you use controlled substances (drugs)?	❑	❑	❑
Do you use tobacco (smoking, snuff, chew, bidis)?	❑	❑	❑
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	❑	❑	❑
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	❑	❑	❑
Number of weeks: _____			
Taking birth control pills or hormone replacement?	❑	❑	❑
Nursing?	❑	❑	❑

Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ❑ ❑ ❑

Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to, or have you had a reaction to: To all **yes** responses, specify type of reaction.	Yes	No	DK
Local anesthetics _____	❑	❑	❑
Aspirin _____	❑	❑	❑
Penicillin or other antibiotics _____	❑	❑	❑
Barbituates, sedatives, or sleeping pills _____	❑	❑	❑
Sulfa drugs _____	❑	❑	❑
Codeine or other narcotics _____	❑	❑	❑
Metals _____	❑	❑	❑
Latex (rubber) _____	❑	❑	❑
Iodine _____	❑	❑	❑
Hay fever / seasonal _____	❑	❑	❑
Animals _____	❑	❑	❑
Food _____	❑	❑	❑
Other _____	❑	❑	❑

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ No ◯ Yes If yes, which? _____

Comments:

For Completion By Dentist

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?. . . . . ❑ ❑ ❑
Name of physician or dentist making recommendation:_____ Phone: (_____)_____
Do you have any disease, condition, or problem not listed above that you think I should know about?. . . . . ❑ ❑ ❑
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevent patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will reyl on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.
Signature of Patient/Legal Guardian: _____ Date: _____

Dental Treatment Consent

.. I authorize dental treatment including local anesthesia, examination, radiographs (x-rays) or diagnostic aids.
2. In general terms, dental treatment may include but is not limited to one or a number of the following:
• Administration of local anesthesia
• Cleaning of the teeth and application of topical fluoride
• Scaling and root planning with local anesthesia
• Application of sealants to the grooves of the teeth
• Treatment of disease or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
• Stainless steel crowns for children. These are necessary in cases where simple filling would not be the best long term restoration or in cases where there are large cavities.
• The replacement of missing teeth with a dental prosthesis (crown, partials, etc)
• Treatment disease or injured oral tissues (hard/or soft)
• Treatment of malposed (crooked) teeth and/or development abnormalities.
• Treatment of canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or (root canal treatment)

Risks of Dental Procedures in General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation of the vein), reaction to injections, change in occlusion (biting), muscles cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of the teeth or restoration in the teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, allergic reactions, itching, bruising, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or all procedures because of conditions found while working on the teeth that were not discovered during examination. Upon being informed, I will give my permission to the dentist to make any/all changes and addition as necessary.

Fillings

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crown (Caps) and Bridges

I understand that sometimes it is not possible to match the color of the natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept in place until the permanent crowns are delivered. I realize the final opportunity to make changes in any new crown or bridge (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge.

Alternative Treatment

I understand that I have the right to choose on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

By signing below, I consent to the general dental treatments and/or proposed treatment.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Parisa Kosha DDS, Inc.
Mario Marroquin DDS, Inc.
17705 Hale Ave, STE G-1, Morgan Hill, CA 95037

MEDICATION LIST

MEDICINE NAME	DOSE	REASON TO TAKE	DATE STARTED	DOCTOR / PHARMACY

Health History Update

Date	Comments	Signature of Patient and Dentist
Date	Comments	Signature of Patient and Dentist
Date	Comments	Signature of Patient and Dentist
Date	Comments	Signature of Patient and Dentist
Date	Comments	Signature of Patient and Dentist
Date	Comments	Signature of Patient and Dentist

FINANCIAL POLICY

Payment for all NEW PATIENT and EMERGENCY visits are required at the time of service, regardless of Dental Insurance Coverage.

A 1.5% monthly billing charge will be assessed on all overdue accounts, regardless of Dental Insurance Coverage.

I assume financial responsibility for all dental treatment and medications provided to me. I understand that payment is expected on the date services are provided.

Although our office will gladly e-file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility. Insurance plans can vary greatly and some companies arbitrarily select certain services that they will not cover. Please contact us if you make any changes to your dental coverage, so that we may keep accurate and current records of your account. Sixty days is the most we can wait for your insurance company to pay your account balances. After this time, we will need you to pay any remaining balances. We will gladly refund you for any overpayment that occur after you have paid your bill.

HIPAA ACKNOWLEDGMENT

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

CANCELLATIONS AND NO-SHOWS

In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to make your appointment. This will allow us to offer your reserved appointment to a patient in urgent need of treatment and promptly reschedule your child for another appointment date. Any appointment(s) not cancelled at least 24 hours in advance is subject to a $50 cancellation fee. We cannot reschedule your appointment until the fee is paid. Continued cancellations and no-shows can result in dismissal from the practice.

Patient's Name: _____
Date: _____
Signature: _____

Parisa Kosha DDS, Inc.
Mario Marroquin DDS, Inc.
17705 Hale Ave, STE G-1, Morgan Hill, CA 95037

HIPPA 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.

This Notice describes the privacy practices of 26th Street Dental. "We" and "our" means the Dental Practice. "You" and "your" means our patient.

How to Contact Us/Our Privacy Official:
If you have any questions or would like further information about this Notice, you can either write to or call the Privacy Official for our Dental Practice.

Dental Practice Name: Parisa Kosha DDS, Inc.
Privacy Official for Dental Practice:
Dental Practice Mailing Address: 17705 Hale Ave, STE G-1, Morgan Hill, CA 95037
Dental Practice Email Address: Smilehavendental.mh@gmail.com
Dental Practice Phone Number: (408) 779-3464

Information Covered by this Notice:

This Notice applies to health information about you that we create or receive and that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- Maintain the privacy of your health information
- Give you this Notice of our legal duties and privacy practices with respect to that information
- Abide by the terms of our Notice that is currently in effect.

Our Use and Disclosure of Your Health Information Without Your Written Authorization

Common Reasons for Our Use and Disclosure of Patient Health Information:

Treatment: We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth, or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment: We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations: We may use and disclose health information about you in connection with health care operations necessary to run our practice, including

review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Appointment Reminders: We may use and disclose your health information when contacting you to remind you of a dental appointment. We may contact you by e-mail, text, letter, postcard, or phone call/voicemail.

Treatment Alternatives and Health Related Benefits or Services:
We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services.

Disclosure to Family Members and Friends: We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, if we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information
The following uses and disclosures occur infrequently and may never apply to you.

Disclosures Required by Law:
We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or det ermine our compliance with HIPAA.

Public Health Activities: We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or con dition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

Health Oversight Activities: We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

Lawsuits and Legal Actions: We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

Law Enforcement Purposes: We may disclose patient health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a

suspect, material witness or missing person or to alert law enforcement of a crime.

Coroners, Medical Examiners and Funeral Directors: We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

Research Purposes: We may use or disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

Serious Threat to Health or Safety: We may use or disclose patient health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

Specialized Government Functions: We may disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

Workers' Compensation: We may disclose patient health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information: We will make other uses and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

Your Rights with Respect to Your Health Information: You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

Access: You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

Amend: If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive

written notice of denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

Restrict Use and Disclosure: You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception. If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

Confidential Communications-Alternative Means, Alternative Locations: You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

Receive a Paper Copy of this Notice: You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

We Have the Right to Change Our Privacy Practices and This Notice: We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website and in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is in the top left-hand corner of the Notice.

To Make Privacy Complaints: If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice. You may also file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights. The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

Patient's Name: _____
Date: _____
Signature: _____