

# DENTAL REGISTRATION AND HISTORY

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

E-mail \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_

\_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2

### DENTAL INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
 I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date \_\_\_\_\_ Relationship to Patient

## 3

### PHONE NUMBERS

Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Spouse's Work (\_\_\_\_) \_\_\_\_\_ Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

## 4

### DENTAL HISTORY

|  |  |   |
|--|--|---|
| Reason for today's visit _____   | Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No       | Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| _____  | Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No         | Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No           |
| Former Dentist _____   | Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| City/State _____   | Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No           | Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No                |
| Date of last dental visit _____  | Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No                         | Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Date of last dental X-rays _____   | Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No                 | Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Place a mark on "yes" or "no" to indicate if you have had any of the following:    | Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No            |
| Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No                | Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No                   | Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No             | Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No                    | Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No        |
| Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No            | Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No |
|  | Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No             | How often do you floss? _____   |
|  | Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No               | How often do you brush? _____   |
|  | Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No    |   |



# 5

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.  Yes  No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

|   |  |                       |  |                                    |  |
|---|--|-----------------------|--|------------------------------------|--|
| AIDS/HIV  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with<br>extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or<br>neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care      | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |
| Do you wear contact lenses?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment   | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |  |

### Women:

Are you pregnant?  Yes  No

Due date \_\_\_\_\_

Are you nursing?  Yes  No

Taking birth control pills?  Yes  No

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

## ALLERGIES

Aspirin

Local Anesthetic

Barbiturates (Sleeping pills)

Penicillin

Codeine

Sulfa

Iodine

Other \_\_\_\_\_

Latex

# 6

## UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what? \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



## Cloudview Dental Financial Agreement:

Name of patient:

Date:

The signee agrees whether he/she signs as guardian or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates as of today the account of Reddy Dental in accordance with the regular rates as deemed by the fee schedule. Should the account be referred for collection, the signee shall pay the attorney's fee and reasonable expenses. If the patients account is sent to collections and failure to pay for services provided in a timely manner it may jeopardize a patients access to routine dental care.

### Minors and Dependent Adults:

All patients under the age of 18 or dependent adults must register the name, address, and social security number of the guardian responsible for the payment.

Either parents or legal guardians may be held responsible for the payment of treatment rendered to their minor child or dependent adult.

In the event of divorce or separation, both parent maybe be held responsible for payment of treatment rendered to their minor child.

Full payment is due on the day of services provided.

Returned checks with insufficient funds will incur a \$25 fee.

All insurance information needs to be registered and updates at the visit when information changes.

Prior approval to the insurance is submitted after presentation of the treatment plan. This is not a guarantee of payment. Patient must initiate the request.

Patients who have dental insurance will pay their estimated portion at the time of service. Once the insurance payment is resolved the patient will be billed/ refunded to any difference in their account.

### Cancellations and broken appointments:

If you are unable to keep your scheduled appointment which is reserved for you, we respectfully request for a prior cancellation notice.

If any procedure less than 90 minutes we request 24 working hours.

Prior notice or 1 business day prior notice not the day of appointment. Which does not give us enough time to fill the spot.

If you have a 90 minute or more procedure, there will be a \$200.00 deposit due at the time of scheduling. If you for some reason cannot make it to the appointment, please give us a 3-business day/ 72 working hours' notice. If you make the appointment on the scheduled day the deposit will go towards your visit, if not the money will be charged for breaking the appointment with not enough notice.

Signature ..... (patient/ guardian)

**Cloudview Dental**  
**3218 N Grimes st, Hobbs, NM 88240**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M / F  
Mailing address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell phone: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
If patient is a minor, parent/guardian name: \_\_\_\_\_  
How do u prefer to be contacted (phone, text, email?): \_\_\_\_\_

**Patient Treatment Consent/Agreement:**

The undersigned authorizes Cloudview Dental to submit claims, (On patient behalf) to dental insurance, or other third-party payer(s) and to disclose health information to the extent necessary to obtain payment. The undersigned also assigns benefits paid by insurance or other third-party payer(s) directly to Cloudview Dental. In consideration of the dental services provided the undersigned assigns to Cloudview Dental any benefits to which the undersigned may be entitled to receive including without limitation any such benefits due or claims the undersigned has under or pursuant to a benefit plan governed under ER13, 29 USC sec 101 et seg.

I have reviewed Cloudview Dental financial policy as listed. I understand and accept responsibility of cooperating with these policies. I understand that I will be responsible for financial balances resulting from treatment received that is not paid by any insurance company or third-party agency. My signature acknowledges that I understand and accept the above agreement.

Print Name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for treatment**

The undersigned consents to radiographs (x-rays), laboratory procedures, anesthesia, diagnostic test, dental treatment, or other procedures rendered to the patient under dentist supervision. Although the undersigned may elect not to undergo certain specific procedures, it is understood that without adequate diagnosis or treatment plan Cloudview Dental may decline to treat the patient.

Print name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

You may refuse to sign this acknowledgment



# Cloudview Dental

## Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, \_\_\_\_\_, have received a copy of Cloudview Dental's Notice of Privacy Practice.

Please print name: \_\_\_\_\_

Signature: \_\_\_\_\_

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

### **Office use only!**

Individual refused to sign \_\_\_\_\_

Communication barriers prohibited obtaining the acknowledgement \_\_\_\_\_

An emergency situation prevented us from obtaining acknowledgement \_\_\_\_\_

Other (please specify):

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## NOTICE OF PRIVACY PRACTICES

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### For Cloudview Dental

**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.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

#### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/30/2021, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

#### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence,



and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

#### **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, from 09/30/21. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

#### **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Telephone: 575-392-7565

Fax: 575-392-0224

E-Mail: [drreddy@reddydental.net](mailto:drreddy@reddydental.net)

Address: 3218 N Grimes St, Hobbs NM 88240



