

*Welcome to  
Rancho San Diego Dental  
2648 Jamacha Rd #166  
El Cajon, CA 92019  
619 670 5571*

**1. Patient's Information**

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

Name: \_\_\_\_\_  
Last First M.I.

Date of Birth \_\_\_\_\_  Male  Female

Home Address: \_\_\_\_\_  
City State ZIP  
Phone# \_\_\_\_\_ Cell# \_\_\_\_\_  
Work# \_\_\_\_\_  
E-Mail \_\_\_\_\_  
SSN \_\_\_\_\_ Driver's License \_\_\_\_\_  
Employer \_\_\_\_\_  
Where & When are the best times to reach you? \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Previous Dentist \_\_\_\_\_

**If patient is a dependent and over the age of 19, does he/she attend school full time?  Yes  No**

**If yes, what is the name and location of the school?**

\_\_\_\_\_

**2. Responsible Party (if different from patient)**

His/Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

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

Date of Birth \_\_\_\_\_ Driver's License \_\_\_\_\_

Relationship \_\_\_\_\_

E-Mail \_\_\_\_\_

**3. Emergency Contact**

Name \_\_\_\_\_

Phone# \_\_\_\_\_

Relationship \_\_\_\_\_

**Payment is due in full at the time of treatment**

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Rancho San Diego Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**4. Insurance  
Primary Insurance**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
City State ZIP

Insurance Co. Phone # \_\_\_\_\_

Group #(Plan, Local or Policy #) \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Birth date \_\_\_\_\_ Relationship \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
City State ZIP

Insured's Phone # \_\_\_\_\_

Insured's SS#/I.D.# \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**Secondary Insurance**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
City State ZIP

Insurance Co. Phone # \_\_\_\_\_

Group #(Plan, Local or Policy #) \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Birth date \_\_\_\_\_ Relationship \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
City State ZIP

Insured's Phone # \_\_\_\_\_

Insured's SS#/I.D.# \_\_\_\_\_

Insured's Employer \_\_\_\_\_

**Continued on Reverse**

**Rancho San Diego Dental  
Patient's Medical Information**

**Patient's Name** \_\_\_\_\_ **Date of Last Physical Exam** \_\_\_\_\_

**Physician's Name** \_\_\_\_\_ **Physician's Phone #** \_\_\_\_\_

**Patient's Medical History**

1. Are you under medical treatment now? .....YES NO  
If so what? \_\_\_\_\_
2. Have you been hospitalized for any surgical operations or serious illness?.....YES NO  
If so what? \_\_\_\_\_
3. Are you taking any medicines including non-prescription medicine? .....YES NO  
If so what? \_\_\_\_\_
4. Have you ever taken Phen-Fen or Redux?.....YES NO

**ALLERGIES TO MEDICINES**

Are you allergic to or have you had any reactions to the following?

- NO KNOWN ALLERGIES**    Local Anesthetics (i.e. Novocain)    Penicillin/Amoxicillin    Sulfa Drugs    Barbiturates    Sedatives  
 Ibuprofen    Aspirin    Latex    Codeine  
 Other \_\_\_\_\_

**Please check the boxes, if you have or have had any of the following.**

- |   |  |
|---|--|
| <input type="checkbox"/> Joint Replacement/Implants/Screws/Pins | <input type="checkbox"/> Anemia  |
| <input type="checkbox"/> Mitral Valve Prolapse                  | <input type="checkbox"/> Emphysema   |
| <input type="checkbox"/> Heart Murmur                           | <input type="checkbox"/> Cancer/Radiation Therapy                                  |
| <input type="checkbox"/> Heart Attack/Heart Disease             | <input type="checkbox"/> Kidney/Liver Disease                                      |
| <input type="checkbox"/> Cardiac Pacemaker                      | <input type="checkbox"/> Venereal Diseases or STD's                                |
| <input type="checkbox"/> High Blood Pressure                    | <input type="checkbox"/> Stomach Troubles/Ulcers                                   |
| <input type="checkbox"/> Low Blood Pressure                     | <input type="checkbox"/> Intestinal Disease  |
| <input type="checkbox"/> Angina/Chest Pains                     | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Rheumatic Fever                        | <input type="checkbox"/> Hay Fever/Allergies                                       |
| <input type="checkbox"/> Hepatitis/Jaundice                     | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Fainting/Seizures                      | <input type="checkbox"/> Recent Weight Loss  |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Weight Reduction Surgery                                  |
| <input type="checkbox"/> Respiratory Problems                   | <input type="checkbox"/> Night Sweats accompanied by weight loss or cough          |
| <input type="checkbox"/> Epilepsy/Convulsions                   | <input type="checkbox"/> Wound that healed slowly or presented other complications |
| <input type="checkbox"/> Leukemia                               | <input type="checkbox"/> AIDS / HIV Infection                                      |
| <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Have you ever been treated for Alcohol or                 |
| <input type="checkbox"/> Thyroid Problems                       | <input type="checkbox"/> Chemical dependency How long ago _____                    |
| <input type="checkbox"/> Tumors or Growths                      |  |

**Women Only**

- Pregnant or think you may be pregnant      Nursing      Taking Birth Control Pills

**Patient Dental History**

1. Do you have pain in or near your ears?..... YES NO
2. Have you ever been told you have TMJ problems?.....YES NO
3. Do you ever have any unhealed injuries or inflamed areas in or around your mouth?.....YES NO
4. Have you ever experienced any growths or sore spots in your mouth?.....YES NO
5. Do you grind or clench your teeth during the night or day?.....YES NO
6. Does any part of your mouth hurt when clenched?.....YES NO
7. Have you ever had any difficult extractions or have prolonged bleeding following extractions?.....YES NO
8. Do your gums bleed?.....YES NO
9. Have you ever had instructions on the care of your gums.....YES NO
10. Do you chew on only one side of your mouth?.....YES NO
11. Do you at the present time have any dental complaints? If so what?.....YES NO  
\_\_\_\_\_
12. Is any part of your mouth or teeth sensitive to; pressure, biting, hot, cold, or sweets..... YES NO  
If so what and where? \_\_\_\_\_
13. **When was your full mouth series of X-rays taken?** \_\_\_\_\_  
**Where** \_\_\_\_\_

**I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor once I have been informed of any fees associated with these procedures. I also authorize the doctor to provide any and all forms of treatment, medication, and therapy that may be indicated. I am aware that it is my responsibility to inform Rancho San Diego Dental of any changes in my health or personal information.**

**Patient's/Guardian's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Dentist's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor's Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Rancho San Diego Dental**  
**NOTICE OF PRIVACY PRACTICES**

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**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.**

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**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 04/14/03 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.

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**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 a 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 authorized 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).

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## **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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request photocopies, we will charge you \$.25 for each copy, \$50 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Duplicated x-rays will be provided at a \$25 fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**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, for the last 6 years, but not before April 14, 2003. 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.

**Restriction:** 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.

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## **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.

Contact Officer: Clare C. Castleberry  
Telephone: 619-670-5571  
Facsimile: 619-670-5592  
Address: 2648 Jamacha Road, Suite 166, El Cajon, CA 92019  
E-mail: rsddental@netscape.net

**Rancho San Diego Dental**

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**PATIENT NAME** (Print) \_\_\_\_\_

**TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: Clare C. Castleberry  
Telephone: 619-670-5571

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**\*\*\* SIGNATURE \*\*\***

I, as the Patient or Patient’s Representative, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

► **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*If this Consent is signed by a Personal Representative on behalf of the patient, please complete the following:*

- **Representative’s Name: (print)** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_
- **Representative’s Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT**

Include completed Consent in the patient’s chart.

**\*\*\*\*\* Acknowledgement of Receipt of Notice of Privacy Practices \*\*\*\*\***

**\* You may refuse to sign this acknowledgement \***

► **Print Patient’s Name** \_\_\_\_\_ **Date** \_\_\_\_\_

► **Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

▪ I, (Print signature name, if signing as Representative) \_\_\_\_\_, have received a copy of this office’s Notice of Privacy Practices. **Representative**

<p>We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:</p> <p><input type="checkbox"/> Individual refused to sign</p> <p><input type="checkbox"/> Communication barriers prohibited obtaining the acknowledgement</p> <p><input type="checkbox"/> An emergency situation prevented us from obtaining acknowledgement</p> <p><input type="checkbox"/> Other (Please Specify) _____</p>
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2648 Jamacha Rd #166  
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619 670 5571*

**Cancellation Policy Acknowledgement**

We know your time is valuable and by implementing certain guidelines regarding appointment cancellations or changing appointments, we feel we can best maximize your time as well as ours by managing a more efficient schedule.

In our office, when you make an appointment, you are reserving the doctor, assistant and the room just for you, so an appointment is really a reservation. There will be a \*fee for canceling or changing your reservation. This fee will be waived by giving us notice of two business days prior to your reserved time.

You are a valued patient and we will gladly assist you in keeping your reservation (appointment) by providing a courtesy reminder by phone. An additional reminder could be arranged to be given anywhere from 1 month to two days prior to your reserved time.

If you prefer to receive an additional courtesy reminder by mail or e-mail please indicate below.

**What is your preferred phone number/s to be contacted?**

1<sup>st</sup> (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home/Work/Cell

2<sup>nd</sup> (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home/Work/Cell

3<sup>rd</sup> (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home/Work/Cell

**Do you prefer to be also contacted by mail or e-mail? If so please provide your address.**

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

Mailing address \_\_\_\_\_

(If different than what is on file)

Patient's Name (Print) \_\_\_\_\_

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

**If this acknowledgement is signed by a Personal Representative on behalf of this patient, please complete the following:**

Representative's Name (Print) \_\_\_\_\_

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

Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*Please note that the cancellation/changing appointment fee would be a minimum of \$60.00 per scheduled hour. This fee would also be applicable if you fail your appointment.**

## Musculoskeletal-Occlusal Signs Exam Form

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

### To be completed by Patient

Please check off any symptoms that may apply

- |   |   |
|---|---|
| 1. <input type="checkbox"/> Headaches                         | 11. <input type="checkbox"/> Facial Pain (Non-Specific)           |
| 2. <input type="checkbox"/> TMJ Pain                          | 12. <input type="checkbox"/> Tender, Sensitive Teeth (Percussion) |
| 3. <input type="checkbox"/> TMJ Noise                         | 13. <input type="checkbox"/> Difficulty Chewing                   |
| 4. <input type="checkbox"/> Limited Opening                   | 14. <input type="checkbox"/> Cervical Pain (Neck)                 |
| 5. <input type="checkbox"/> Ear Congestion                    | 15. <input type="checkbox"/> Postural Problems                    |
| 6. <input type="checkbox"/> Vertigo (Dizziness)               | 16. <input type="checkbox"/> Paresthesia of Fingertips (Tingling) |
| 7. <input type="checkbox"/> Tinnitus (Ringing in the Ears)    | 17. <input type="checkbox"/> Thermal Sensitivity (Hot and Cold)   |
| 8. <input type="checkbox"/> Dysphagia (Difficulty Swallowing) | 18. <input type="checkbox"/> Trigeminal Neuralgia                 |
| 9. <input type="checkbox"/> Loose Teeth                       | 19. <input type="checkbox"/> Bell's Palsy                         |
| 10. <input type="checkbox"/> Clenching/Bruxing                | 20. <input type="checkbox"/> Nervousness/Insomnia                 |

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### To be completed by Doctor

#### SIGNS (Extra-oral)

- Facial Asymmetry Bilaterally
- Short Lower Third of the Face
- Chelitis
- Abnormal Lip Posture
- Deep Mentalis Crease
- Dished-Out or Flat Labial Profile
- Facial Edema
- Mandibular Torticollis
- Cervical Torticollis
- Forward Head Posture (Lordosis)
- Elongated Lower Face (Steep Mandibular Angle)
- Speech Abnormalities

#### SIGNS (Intra-oral)

- |  |  |
|--|--|
| 1. <input type="checkbox"/> Crowded Lower Anteriors  | 18. <input type="checkbox"/> Chipped Anterior Teeth                            |
| 2. <input type="checkbox"/> Wear of Lower Anterior Teeth                                   | 19. <input type="checkbox"/> Loss of Molars                                    |
| 3. <input type="checkbox"/> Lingual Inclination of Lower Anteriors                         | 20. <input type="checkbox"/> Open Interproximal Contacts                       |
| 4. <input type="checkbox"/> Lingual Inclination of Upper Anteriors (Div II Occlusion)      | 21. <input type="checkbox"/> Unexplained Gingival Inflammation and Hypertrophy |
| 5. <input type="checkbox"/> Bicupid Drop Off   | 22. <input type="checkbox"/> Crossbite   |
| 6. <input type="checkbox"/> Depressed Curve of Spee  | 23. <input type="checkbox"/> Anterior Open Bite                                |
| 7. <input type="checkbox"/> Lingually Tipped Lower Posteriors                              | 24. <input type="checkbox"/> Anterior Tongue Thrust                            |
| 8. <input type="checkbox"/> Narrow Mandibular Arch   | 25. <input type="checkbox"/> Lateral Tongue Thrust                             |
| 9. <input type="checkbox"/> Narrow Maxillary Arch (High Palatal Vault)                     | 26. <input type="checkbox"/> Scalloping of the Lateral Border of the Tongue    |
| 10. <input type="checkbox"/> Midline Discrepancy   |  |
| 11. <input type="checkbox"/> Malrelated Dental Arches                                      |  |
| 12. <input type="checkbox"/> Tooth Mobility  |  |
| 13. <input type="checkbox"/> Flared Upper Anterior Teeth                                   |  |
| 14. <input type="checkbox"/> Facets  |  |
| 15. <input type="checkbox"/> Cervical Erosion (Abfractions)                                |  |
| 16. <input type="checkbox"/> Locked Upper Buccal Cusps                                     |  |
| 17. <input type="checkbox"/> Fractured Cusps (Particularly C1 I & II Non-Functional Cusps) |  |

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