ANDREW C. DREYER, DDS, MS
PERIODONTICS & DENTAL IMPLANTS

Date _____

REGISTRATION FOR MINORS

Last Name | First | MI | Date of Birth

Mailing Address | City | State | Zip

Home Phone | Cell Phone

General Dentist | City | How Long?

GUARDIAN INFORMATION

Child Resides With: Both Parents _____ Mother _____ Father _____ Other _____

Mother/Guardian | Date of Birth

Father/Guardian | Date of Birth

Mother Phone # | Father Phone #

E-Mail Address

DENTAL INSURANCE INFORMATION

Primary Insurance | Secondary Insurance

Primary Ins. Company Address | Secondary Ins. Company Address

Group Name/Number | Group Name/Number

PERSONAL INFORMATION

Whom may we thank for referring you to our office? _____

How would you prefer we address you (e.g. first name, nickname, or more formally)? _____

Is there some way in which we may make treatment visits easier for you? _____

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MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____

Physicians (please list your family physician and any medical specialists you see at least once a year):

Name	Address	City	Phone #	Specialty

Approximate date of last physical examination:_____

Medications that you take on a regular basis:

Do you have (or have you had) any of the following?:

Yes	No	Allergic reaction to (select all that apply)			
		Latex	Penicillin	Aspirin	Codeine
		Narcotics	Acetaminophen	Local Anesthetics	Other
Yes	No	Heart attack or heart disease (date ___)			
Yes	No	Heart surgery (date_____)			
Yes	No	Stroke (date_____)			
Yes	No	Mini stroke/TIA (date_____)			
Yes	No	High blood pressure			
Yes	No	Congestive heart failure			
Yes	No	Angina (chest pains)			
Yes	No	Irregular heart beat			
Yes	No	Artificial heart valve			
Yes	No	Rheumatic fever, rheumatic heart disease			
Yes	No	Bacterial endocarditis (SBE)			
Yes	No	Congenital heart disease			
Yes	No	Immunosuppressive condition (select all that apply)			
		Steroid therapy (e.g. Prednisone)	Radiation therapy	Chemotherapy	
		SLE (Lupus)	Rheumatoid arthritis	HIV	
		Organ transplant	Spleen removed	Other	
Yes	No	Artificial implants or devices (select all that apply)			
		Hip	Knee	Ankle	Shoulder	Other
		Date(s) placed:_____				
Yes	No	Other artificial implants or devices			
Yes	No	Bleeding problem, anemia, other blood diseases			
Yes	No	Diabetes			
Yes	No	Thyroid disease			
Yes	No	Nervous system disease or seizures			
Yes	No	Stomach (i.e. ulcer) or intestinal diseases (Crohn's, IBS, etc.)			
Yes	No	Kidney disease			
Yes	No	Hepatitis (A, B, C, or D)			
Yes	No	Other liver disease			
Yes	No	Arthritis (Osteo or Rheumatoid)			
Yes	No	Other muscle or joint disease			
Yes	No	Asthma			
Yes	No	Tuberculosis			

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MEDICAL HISTORY

Yes No Other lung disease
Yes No Mental health condition – specifically:_____
Yes No Physical or mental disabilities that may require special care
Describe:_____
Yes No Do you have or have you ever been treated for cancer?
If you answered yes, how was it treated?_____
Yes No Do you have any diseases, conditions, or problem not listed here?
Describe:_____
Yes No Have you ever been hospitalized or had surgery?
Describe:_____
Yes No Dr you have any undiagnosed symptoms?
Describe:_____
Yes No Are you, or have you ever been addicted to a chemical substance?
(examples: alcohol, prescription drugs, heroin, meth, cocaine, other)
Yes No Do you smoke tobacco products?
How much and how often?_____
Yes No Do you regularly consume alcoholic products?
How much and how often?_____
Yes No Do you regularly take herbal medicines or dietary supplements? (select all that apply)

Echinacea	Garlic	Ginger	Kava	Valerian	Feverfew
Ginkgo	Ginseng	St. John's Wort	Vitamin E	Other:	

Yes No Have you received injections or taken medication for past osteoporosis therapy or bone cancer?
(Examples are: Fosamax, Boniva, Prolia, etc.)
Yes No Have you taken steroids (cortisone, etc.) in the past 12 months? Date:_____
Yes No Have you had a prolonged illness and hospitalization experience during the past 5 years?
Describe:_____

Females
Yes No Are you or could you be pregnant
Yes No Do you take birth control pills?
Yes No Have you completed Menopause?
Yes No Do you have hormone replacement (HRT)?
Yes No Are you nursing?

Other Health information of concern?_____
_____

At each dental appointment please advise us of changes in your health status.
(e.g. pregnancy, cardiac distress, hospitalization, prolonged illness,…)

Patient signature:_____ **Date:**_____

Thank you for helping us to help you

Reviewed by:	**Premed. indicated?**	**Date:**

Andrew C. Dreyer, DDS, MS
A Professional Dental Corporation

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Bakersfield, CA 93312
(661)665-0077
bakersfieldperiodontics.com



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: October 1, 2015

This Notice of Privacy Practices applies to the following organizations.

Privacy Official: Lori (lori@bakersfieldperiodontics.com)