Thomas P. Collins, D.D.S.

Time-honored patient care…
State of the art dentistry.

PATIENT REGISTRATION

Please complete the following confidential information

Date

Last Name	First Name	MI
Address		
City	State	Zip
Home Phone No.	Cell Phone No.	
Work Phone No.	Fax Phone No	
Date of Birth	Email	

Marital Status

Single	Married	Divorced	Widowed

Social Security No.

If this appointment is for your child, start here:

Last Name	First Name	MI
Address:		
City	State	Zip
Home Phone No.	Cell Phone No.	
Date of Birth	Male	Female
School	Grade	
Social Security No.		

Account Information

Person Financially Responsible for Account

Name		
Relationship to Patient	Social Security No.	
Address		
City	State	Zip
Home Phone No.	Cell Phone No.	
Work Phone No.		

Dental Insurance

Primary Carrier

Insurance Company	
Group No.	
Employer Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insured's ID No.	
Insured Social Security No.	

Secondary Carrier

Insurance Company	
Group No.	
Employer Name	
Insured's Name	
Date of Birth	Relationship to Patient
Insured's ID No.	
Insured's Social Security No.	

GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office?

Name:	**Relationship:**	
You were referred to us by:		
Person to contact for emergency:		
Phone No.	Cell Phone No.	
Address		
City	State	Zip

Please complete information on page 2 and sign form

Thomas P. Collins DDS * 1321 S. Eliseo Drive * Greenbrae * CA *94904
Telephone: 415.461.5926 * Fax: 415.461.6857

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study materials, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ________________________________’s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor’s or designated staff’s use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5 finance charge may be added to my account. If required, I also understand a check of my credit history may be made.

Patient’s Signature ______________________________ Date ____________

Witness ______________________________

Parent/Responsible Party’s Signature ______________________________

Relationship to patient ______________________________

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MEDICAL HISTORY FORM

Patient Name		
Physician:	Physician phone number:	
Have you been under the active care of a physician for an ongoing issue over the past two years? If yes, please describe:		Y N
Are you currently taking any medications, drugs, pills, herbal remedies, including aspirin? If yes, please list.		Y N
Have you taken prescription medications for weight loss, such as Fen-Phen, Pondimen, or Redux?		Y N
Have you taken prescription medications for bone density such as Fosamax, Actonel, or Boniva?		Y N
Have you ever had an adverse or allergic reaction of any medications? If so, please list.		Y N
Have you been admitted to the hospital in the last 5 years? For:		Y N

Have you had or currently have any of the following:

Cardiology:			**Endocrine:**			**Immunologic:**		
Heart Condition	Y	N	Liver disease/Yellow Jaundice	Y	N	Cold sores/fever blisters	Y	N
Chest Pain	Y	N	Thyroid Problems	Y	N	Blood Transfusion	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N	Hay Fever/Allergy/Hives	Y	N
High/Low Blood Pressure	Y	N	**Respiratory:**			Latex sensitivity	Y	N
Mitral Valve Prolapse	Y	N	COPD/Emphysema	Y	N	**Neurologic**:		
Artificial Heart Valve/Pacemaker	Y	N	Chronic Cough	Y	N	Neurological Disorders	Y	N
Stroke	Y	N	Tuberculosis	Y	N	Epilepsy or Dizzy spells	Y	N
Swollen Ankles/Bruise Easily	Y	N	Asthma	Y	N	Nervous/Anxious	Y	N
Rheumatic Fever	Y	N	Sinus Trouble	Y	N	Psychiatric/Psychological Care	Y	N
Hemophilia/Sickle Cell	Y	N						
Musculoskeletal:						**Neoplastic**:		
Arthritis/Rheumatism	Y	N	**Acquired Diseases**:			Tumors / cancer	Y	N
Artificial Joints	Y	N	Hepatitis A, B or C	Y	N	Radiation/Chemotherapy	Y	N
Gastro-urologic:			Venereal Disease	Y	N			
Kidney Trouble	Y	N	HIV/AIDS	Y	N	**Other:**		
Ulcers	Y	N				Diet (special or restricted)	Y	N
Diabetes	Y	N				Contact Lenses	Y	N

Have you had any diseases or conditions not listed above? Yes No if yes, what?____
Have you gained or lost more than 10 pounds in the past year? Yes No if yes which?______________________________________
Women: Are you pregnant or think you could be pregnant? Yes No if yes how far along?____________________________________
Women: Are you nursing Yes No Women: Are you using birth control prescriptions? Yes No
Anything else you would like to share?

I understand the above information is necessary to provide me with dental care in a safe and caring manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency. I will notify the doctor or any change in my health or medication.

____ ____________________________
Patient Signature Date

Doctor's Notes: ____

____

____

____ ____________________________
Doctor's signature Date

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DENTAL HISTORY FORM

Patient Name		
Previous Dentist Name, City, State		
Date of last dental visit	Date of last dental cleaning	Date of last full mouth x-rays
Do you have any current dental concerns? Y N If "yes" please describe.		

Teeth:			**Prior care/conditions**: Have you ever had?		
Acute hot/cold?	Y	N	Orthodontics?	Y	N
Sweets?	Y	N	Oral Surgery?	Y	N
Biting/chewing?	Y	N	Gum Surgery?	Y	N
Food caught between, where?	Y	N	Bite adjusted? Does your bite change?	Y	N
Gums:			Do your teeth feel worn down?	Y	N
Bad odor or taste	Y	N	Wear a nightguard?	Y	N
Bleed or hurt	Y	N	Serious injury to mouth or head?	Y	N
Parents lost teeth to gum disease	Y	N	Clicking, popping, locking of the jaw?	Y	N
Habits:			Difficulty opening or closing?	Y	N
Clench or grind daytime/nighttime?	Y	N	Difficulty chewing on one side?	Y	N
Have tired jaws in the morning?	Y	N	Headache, shoulder ache or neck problems?	Y	N
Bite your lips or cheeks regularly	Y	N	**Smile:**		
Hold pencils, nails, or bite fingernails with your teeth?	Y	N	Are you happy with your smile? If no, what would you change?	Y	N
Mouth breath, snore or have a sleeping disorder?	Y	N			
Smoke or chew tobacco?	Y	N	**Anxiety:**		
Medications: Do you require premedication before dental care?	Y	N	Have you ever had an upsetting dental experience? If so please describe.	Y	N
			Are you nervous about dental treatment? If so, what is your biggest concern?	Y	N

Other:

Is there anything else you would like us to know?

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Thomas P. Collins, DDS A Professional Corporation

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 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 immediately, 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 we created or received that we maintain, including health information we created or received before we made the changes. Before we make any significant change in your privacy practices, we will change the Notice and make the new Notice available upon request.

You may request a copy of the 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 the 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 information to obtain payment for services we provide 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 the 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, or 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 letter).

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 copies, we will charge you $0.10 for each page, $10 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. 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy 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: Pamela Collins

Telephone: 415-461-5926 Fax: 415-461-6857

Address: 1321 S Eliseo Drive, Greenbrae, CA 94904

THOMAS PATRICK COLLINS, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse to Sign This Acknowledgement**

I,____, have received a copy of this office's Notice of Privacy Practices.

____

Please Print Name

____

Signature **Date**

For office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ **Individual refused to sign**
- □ **Communications barriers prohibited obtaining the acknowledgement**
- □ **An emergency situation prevented us from obtaining acknowledgement**
- □ **Other (Please Specify)**

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