**444B St. Michaels Dr. Santa Fe, New Mexico 87505**
**(505) 989-8749**

## PATIENT INFORMATION

NAME ______________________ BIRTHDATE __________
SOC. SEC. NO. ______________________
MAILING ADDRESS (Street) ______________________
City ______________ State __________ Zip __________
HOME ADDRESS ______________________
HOME PHONE ______________ WORK PHONE ______________
CELL PHONE ______________________
(LIST BEST PHONE # AND TIME TO REACH YOU) ______________
EMAIL ADDRESS ______________________
YOUR OCCUPATION ______________ EMPLOYER ______________
SPOUSE'S NAME ______________ WORK PHONE ______________
SPOUSE'S SOC. SEC. NO. ______________________
Legal Guardian or Parent's Name (if patient is a child) ______________
PHONE ______________________
PERSON OTHER THAN SPOUSE TO BE NOTIFIED IN CASE OF EMERGENCY __________
______________________
PHONE ______________________
MEDICAL PHYSICIAN ______________________
PHONE ______________________

## HEALTH HISTORY

This information will be confidential and is necessary to allow us to give you our best treatment.
Please check yes or no to whether you have or haven't had any of the following:

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ___ | ___ | Heart problems | ___ | ___ | Radiation treatments |
| ___ | ___ | Heart murmur | ___ | ___ | Blood transfusion (date _______) |
| ___ | ___ | High or low blood pressure | ___ | ___ | HIV+, AIDS or exposure to AIDS |
| ___ | ___ | Pain, pressure, tightness in chest | ___ | ___ | Venereal disease |
| ___ | ___ | Circulatory problems | ___ | ___ | FEMALES: currently pregnant (check yes if possibility exists) |
| ___ | ___ | Rheumatic fever | | | |
| ___ | ___ | Periodontal disease | ___ | ___ | Antidepressant medication |
| ___ | ___ | Bleeding gums | ___ | ___ | Psychiatric care or psychotherapy |
| ___ | ___ | Sinus problems | ___ | ___ | Nervous problems |
| ___ | ___ | Temporomandibular dysfunction | ___ | ___ | Ulcer |
| ___ | ___ | Cold sores | ___ | ___ | Stroke |
| ___ | ___ | Herpes | ___ | ___ | Anemia |
| ___ | ___ | Thyroid problems | ___ | ___ | Arthritis |
| ___ | ___ | Excessive bleeding | ___ | ___ | Epilepsy |
| ___ | ___ | Diabetes | ___ | ___ | Kidney or bladder disease |
| ___ | ___ | Hepatitis, A, B, or C, Jaundice (date ___________) | ___ | ___ | Artificial joints |
| ___ | ___ | Malignancies/Cancer | ___ | ___ | Lung problems (T.B., asthma, emphysema) |
| ___ | ___ | Other, if so, what: ______________ | | | |

Do you have or have you had allergic reactions to the following:

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| ___ | ___ | Penicillin | ___ | ___ | Codeine |
| ___ | ___ | Tetracycline | ___ | ___ | Latex/Vinyl |
| ___ | ___ | Erythromycin | ___ | ___ | Dental anesthetics |
| ___ | ___ | Tylenol | ___ | ___ | Other, if so, what: ______________ |
| ___ | ___ | Aspirin | | | |
| ___ | ___ | Ibuprofen | | | |

Do you need to be pre-medicated for any medical condition ____ yes ____ no ____ not sure
Are there any other medical conditions we should know about? ______________
______________________
Are you or have you ever taken cortisone? ______________
Do you use tobacco? ______________ What type? ______________
Do you take any herbal remedies ____ yes ____ no If yes, what: ______________
Date of last dental exam: ______________ and cleaning: ______________
Have you had any problems with previous dental treatment _______ yes _______ no
If yes, explain: ______________________
______________________
Are you interested in improving your smile? ____ yes ____ no
If yes, how? ______________________
______________________

Please list ALL medications you are currently taking:

| WHAT MEDICATIONS: | REASON FOR: |
|---|---|
| ______________ | ______________ |
| ______________ | ______________ |
| ______________ | ______________ |
| ______________ | ______________ |

Please list all hospitalizations: ______________________
______________________
If yes, explain: ______________________
______________________
Whom may we thank for referring you? ______________________

## FINANCING INFORMATION

If you are interested in pre-qualifying for interest-free financing check yes below, sign and answer the following questions.
YES _____ Signature: ______________________
What is your nearest relative's name ______________________
Nearest relative's phone number ______________________
What is you net monthly income ______________________
Do you rent or own your home ______________________
Driver's License # ______________________
Driver's License State ______________ Exp. date ______________

**To the best of my knowledge the above information is complete and correct.**
**I understand that I am responsible for payment in full at the time of service.**
**Patient or guardian signature** ______________________ **Date** __________

## INFORMATION AND CONSENT

We would like you, our patient, to be fully informed about the various procedures involved in your treatment and we will require your written consent before starting treatment.

GENERAL RISKS OF DENTAL CARE: Included (but not limited to) are complications resulting from the use of dental instruments and medicines such as: antibiotics, analgesics (pain medications), and local anesthetic injections. These complications may include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations and treatment failure.

SPECIFIC RISKS: The treatment that we have recommended, [Inlay/Onlay, Crown, Bridge] is intended to correct conditions in your mouth that can ultimately lead to worsening complications or tooth loss. During treatment, complications may be discovered which make treatment impossible, or which may require corrective dental surgery. These complications may include exposure of the tooth pulp or fractures of the teeth. Usually these complications are due to the condition of the gums and/or bone or previous restorations and cannot be foreseen either by clinical or radiographic examination.

MEDICATIONS: Some prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs.) It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Some antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Women who are taking oral contraceptives, and are given a prescription for an antibiotic, are strongly advised to use additional means of birth control during the entire monthly cycle for which the antibiotic has been used.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices may include pain, infection, swelling, loss of teeth, and spread of infection in other areas. The risks of these alternative treatments are often more severe than those of root canal therapy.

CONSENT: *I the undersigned, being the patient (parent or guardian of patient) consent to performing the procedures decided to be necessary or advisable in the opinion of the doctor. I understand that this treatment is an attempt to save a tooth, and that even though this therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had previous treatment may require re-treatment, corrective surgery or even extraction.*

*I hereby state that I have read and understand this consent. I have been given the opportunity to question the doctor, and all questions about the procedure(s) have been answered in a complete and satisfactory manner. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment.*

**Patient/Guardian Initial__________ Date ____________**

### REFERRAL DISCLAIMER

Any referral to another professional is provided as merely a convenience to you. This office may provide references to other practitioners but Gabriel Roybal DDS has not reviewed these other facilities or practitioners, has no responsibility for the services provided by such other practitioners and shall not be liable for any damages or injury arising from their services. You understand that, except for information or services clearly identified as being supplied by Gabriel Roybal, DDS, this office does not operate, control or endorse any information, products or services provided by another practitioner or practice in any way. Gabriel Roybal DDS does not endorse or make any representations about any practitioner or practice it refers, or any information or other products or materials found through such practice, or any results that may be obtained from using these practitioners or the services or products they provide. If you decide to utilize any of these referred practitioners and the services and products they provide, you do so entirely at your own risk.

**Patient/Guardian Initial__________ Date ____________**

| DATE | TREATMENT RENDERED | DATE | TREATMENT RENDERED |
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City Different Dentistry
444 St Michaels Dr Suite B
Santa Fe, NM 87505
505-989-8749

# Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

______________________________ ______________

**PATIENT NAME** **DATE**

**I understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

**I understand** that City Different Dentistry may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

City Different Dentistry has a detailed document called the *'**Notice of Privacy Practices**'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

**I understand** that I have the right to read the *'Notice'* before signing this agreement. If I ask, City Different Dentistry will provide me with the most current *Notice of Privacy Practices.*

**My signature** below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow City Different Dentistry to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that City Different Dentistry has taken action relying on this consent.

______________________________ ______________

**SIGNATURE** (Patient or Legal Custodian/Authorized Representative) **DATE**

______________________________ ______________

**Relationship to Patient** if signed by another party **DATE**

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: City Different Dentistry at 444 St Michaels Dr Suite B, 505-989-8749,.

**FORM Us**



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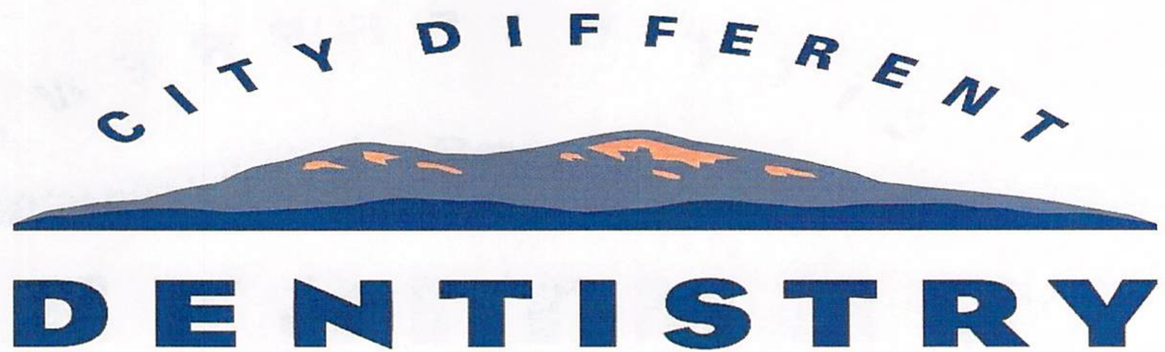
HIPAA Compliance Program




*I understand the policy for* City Different Dentistry *regarding cancellations and changes. The policy is as follows; 48 hrs. notice for any changes or cancellations. This is to ensure that the Dr's time is utilized wisely and that we may get another appointment in if someone is in need. We do respect your time in taking care of you properly; we ask you to respect our time as well. I understand that I will be responsible for a $50 no show fee if cancelled less than 48hrs. Thank you for your cooperation.*

______________________________________________________________

***Sign*** ***Date***

*Phone 505-989-8749 * Fax 505-988-3298*

CITY DIFFERENT

# DENTISTRY

Cosmetic | General | Prosthodontic Specialty

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

City Different Dentistry
444 St. Michaels Drive Suite B
Santa Fe NM 87505

**I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS DENTAL OFFICE'S NOTICE OF PRIVACY PRACTICES.**

**PATIENT'S NAME (PRINT)** ________________________________________

OTHER(S) WHO WE MAY RELEASE YOUR PERSONAL INFORMATION: NAME(s)
________________________________________________________________

**SIGNATURE**: ______________________________ **DATE**: ____-____-____

**NAME OF PERSONAL REPRESENTATIVE AND RELATIONSHIP IF PATIENT IS A MINOR OR INCAPACITATED:**
**NAME:** ________________________________________
**RELATIONSHIP:** ________________________________________

**NOTE: YOU MAY REFUSE TO SIGN THIS FORM. IF THE SIGNATURE IS NOT OBTAINED, THE OFFICE MUST PROVIDE THE FOLLOWING INFORMATION.**

We attempted to obtain a written **Acknowledgment of Receipt of our Notice of privacy Practice** but we were unable to due to:

[ ] **The patient (or person representative) refused to sign**

[ ] **Inability to communicate (communication problems)**

[ ] **Emergency situation**

[ ] **Other:** ________________________________________

Privacy Officer: City Different Dentistry

**SIGNATURE of Officer:** ______________________________ **DATE:** ____-____-____

# PRIVACY NOTICE (NOTICE OF PRIVACY PRACTICES)

City Different Dentistry
444 St. Michaels Drive #B
Santa Fe, New Mexico 87505

This notice is being given to you to ensure our compliance with the Health Insurance Portability and Accountability Act (H.I.P.P.A.) of 1996. We support the effort to protect patient confidentiality and the security of individual health information.

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

This notice is effective April 14, 2003.

Statement of Our Duties
We are committed to maintaining the privacy of your personal health information and to comply with all state and federal privacy laws. The purpose of this Privacy Notice is to inform you of our privacy practices and the legal duties. We are required to:

*maintain the privacy of protected health information;
*provide you with this notice of our legal duties and privacy practices with respect to your health information;
*abide by the terms of this notice;
*notify you if we are unable to agree to your requested restriction on how your information used or disclosed;
*accommodate reasonable requests that you may make to communicate health information by alternative means or at alternative locations;
*obtain those identified in this notice and permitted under law.

We reserve the right to change our information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be provided to you by mail.

Statement of Your Rights
You have the right to know how we may use or disclose your personal health information. This notice informs you of those uses and disclosures. There are certain uses and disclosures of your personal health information that we are permitted or required to make by law without your permission. For all other uses and disclosures, we first must obtain your permission. In addition, you have the following rights:

*The right to request that we place additional restrictions on our uses and disclosures of your personal health information. however, we are not obligated to agree to follow any such additional restrictions.
*The right to access, inspect and copy your protected health information which we maintain in our files about you, and the right to have us correct or amend any information that we create in error. Request to access or amend your health information should be sent to the contact person and address provided at the end of this notice. We have the right to charge you for this service.
*The right to receive an accounting of your disclosures of your personal health information that we make for purposes other than activities related to your treatment, payment functions or other health care operations.
*The right to request that you receive communications of personal health information in a confidential manner.

Information We Collect About You
We collect the following categories of information about you from the following sources:

*Information that we obtain directly from you, in conversations or in a form that you fill out.
*Information that we obtain as a result of your treatment in this office.
*Information that we obtain from your medical or dental records or other related professionals.
*Information that we obtain from other entities, such as health care providers or insurance companies, in order to carry out health care operations.

Permissible Uses and Disclosures of Protected Information

*To Carry Out Treatment Functions. We may use or disclose your health information without your permission

in order for other health providers, including laboratories to provide you with treatment.

*To Carry Out Payment Functions. We may use or disclose your health information without your permission to carry out activities related to obtaining payment for the provision of health care, determining coverage, and accessing your benefits under the insurance that you have.

*To Carry Out Certain Operations Relating to Your Healthcare. We also may use or disclose your protected health information without your permission to carry out certain limited activities including reviewing competence or qualifications of health care professionals, conducting quality assessment activities, conducting training, accreditation certification, licensing or credentialing activities.

*In Situation Permitted or Required By Law. We also may use or disclose your protected health information without your written permission for other purposes permitted or required by law, including the following:

- -As authorized by and to the extent necessary to comply with workers compensation or other no fault laws.
- -To a health oversight agency for activities including audits or civil, criminal, or administrative proceedings.
- -To a public health authority for purposes of public health activities (such as to the Food and Drug Administration to report consumer product defects.)
- -To law enforcement official for law enforcement purposes or in response to a court order or in the course of any judicial or administrative proceeding.
- -For approved research purposes.
- -To a government authority including a social service or protective service agency, authorized to receive reports of abuse, neglect or domestic violence.

*For Purpose for Which We Have Obtained Your Written Permission. All other uses or disclosures such as marketing services of your protected health information will be made only with your written permission, and you may revoke any permission you give us at that time.

Complaints About Misuse of Health Information

You may complain either directly to us or to the Security of Health and Human Services if you believe that your rights with respect to our protection of your health information has been violated. You may file a complaint with us by submitting in Writing to the address below that includes as many details (such as names and dates) as possible. You will not be retaliated against in any way for filing a complaint.

Our Practice Regarding Confidentiality and Security

We restrict access to non-public personal information about you to those employees who need to know that information in order to provide our health care or service to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your non-public personal information.

Our Policy Regarding Dispute Resolution

Any controversy or claim arising out of or relating to our privacy policy, or the breach thereof, shall be settled by arbitration in the state courts, in accordance with the rules of the American Arbitration Association and judgement upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

Filing a Complaint:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independent Avenue SW
Room 509F HHHBuilding
Washington, D.C. 20201