



New Patient Package

ADA American
Dental
Association®
America's leading
advocate for oral health



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NUOVA DENTAL OFFICE

PATIENT REGISTRATION

Patient Personal Information					
Title		Nickname		Birth Date	
Last, First				Marital Status	
Address				Home #	
				Cell #	
City, State, Zip				Student	
Email				School Name	
				Referral Type	

Person responsible/guarantor for paying bills					
Title		Nickname		Birth Date	
Last, First				Marital Status	
Address				Home #	
				Cell #	
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance?	No	Do you have Secondary Dental Insurance?	Yes	No
Group No/Name		Group No/Name		
Insurance Name		Insurance Name		
Phone #		Phone #		
Employer Name		Employer Name		
Subscriber Last, First		Subscriber Last, First		
Subscriber Address		Subscriber Address		
City, State, Zip		City, State, Zip		
Relationship to Patient		Relationship to Patient		
		Birth Date		
Subscriber ID		Subscriber ID		

Patient Medical Information			
Allergic To	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Anorexia	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Persistent Diarrhea
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis	<input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters	<input type="checkbox"/> Y <input type="checkbox"/> N Premedicate
<input type="checkbox"/> Y <input type="checkbox"/> N Barbiturates / Sleeping Pills	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Frequently Dry Mouth / Sjogren	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Gag Reflex	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Heart Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Iodine	<input type="checkbox"/> Y <input type="checkbox"/> N Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Gall Bladder Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatoid Arthritis
<input type="checkbox"/> Y <input type="checkbox"/> N Latex Rubber	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Clotting Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures
<input type="checkbox"/> Y <input type="checkbox"/> N Local Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Sexually Transmitted Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath
<input type="checkbox"/> Y <input type="checkbox"/> N No Epinephrine	<input type="checkbox"/> Y <input type="checkbox"/> N Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Tumor or Growth	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble
<input type="checkbox"/> Y <input type="checkbox"/> N Prior Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiac Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa Drugs	<input type="checkbox"/> Y <input type="checkbox"/> N Cardiovascular Disease	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Other Narcotics	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Hives	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems
Check, if applicable	<input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain Upon Exertion	<input type="checkbox"/> Y <input type="checkbox"/> N Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N No Change Since Last Recorded	<input type="checkbox"/> Y <input type="checkbox"/> N Color Blindness	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Unusual Weight Loss
<input type="checkbox"/> Y <input type="checkbox"/> N No Known Concerns or Issues	<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney	<input type="checkbox"/> Y <input type="checkbox"/> N Urinate Frequently
	<input type="checkbox"/> Y <input type="checkbox"/> N Contact Lenses	<input type="checkbox"/> Y <input type="checkbox"/> N Leukemia	Other
		<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Congestive Heart Failure | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N See Scanned Documents: Pt Note |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Infection | <input type="checkbox"/> Y <input type="checkbox"/> N Damaged Heart Valve | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Mental Health Problems | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Angina | <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Environmental Allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Ankles Swell | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | | |

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist _____

Phone _____

Date of your last cleaning _____

Last exam date _____

Date of your last full series x-rays _____

Date of last cavity detection (bitewing) x-rays _____

Do your gums bleed while brushing or flossing ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you ever had burning of the tongue or cracking of the corners of your mouth ? _____

Do you chew/smoke tobacco in any form ? _____

Have you had any head, neck or jaw injuries ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Do you clench or grind your teeth ? _____

Have you ever had orthodontic treatment ? _____

If Yes, date of placement _____

Do you wear dentures or partials ? _____

If Yes, date of placement of dentures ? _____

Are you happy with your dentures ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Are you happy with your smile ? _____

Do you have problems with teeth/fillings breaking ? _____

Do you regularly use dental floss ? _____

Do you have ever been told you have Pyorrhea ? _____

Do you have difficulty in opening your mouth widely ? _____

Do you have an unpleasant taste or odor in your teeth/mouth ? _____

Does food catch between your teeth ? _____

Do you want to learn to control your dental disease and retain your teeth ? _____

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Medical Questionnaire**Emergency Contact**

Emergency contact name _____

Emergency contact phone _____

Emergency contact relationship to patient _____

Medical Questionnaire

Family Physician _____

Phone _____

Are you currently under care of a Physician ? _____

If Yes, what is the condition being treated ? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years ? _____

If Yes, what illness or problem ? _____

Are you currently taking any medication ? _____

If Yes, what ? _____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) _____

Have you ever taken the diet control drug Fen-Phen ? _____

Do you use alcoholic beverages ? _____

Do you smoke ? _____

Women Only

Are you pregnant? _____

If Yes, what is your due date ? _____

Are you currently nursing ? _____

Do you have menstrual period problems ? _____

Are you on hormone replacement therapy ? _____

Are you on birth control pills / fertility drugs ? _____

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature_____
Date

INFORMED CONSENT FOR GENERAL DENTISTRY

Name : _____

1. WORK TO BE DONE: I understand that I am having one or more of the following work done in the office of Nuova Dental Office: Fillings, Bridges, Crowns, X-rays, Extractions, Impacted teeth removed, Root Canals, Dentures, Cleanings, Periodontal treatment.

Initials _____

2. DRUGS AND MEDICATION: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock.

Initials _____

3. CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example: root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.

Initials _____

4. REMOVAL OF TEETH: Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.), and I authorize the dentist to remove the necessary affected tooth/teeth if the treating dentist deems the removal necessary to improve my dental health. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed; some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (that can last for an indefinite period of time), or a fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.

Initials _____

5. CROWNS, BRIDGES, AND CAPS: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown bridge, or cap (including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying permanent cementation.

Initials _____

6. ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand I may need further treatment by an endodontic specialist if complications arise during or following treatment, the cost for which is my responsibility. I understand that the tooth may be lost in spite of all efforts to save it.

Initials _____

7. PERIODONTAL LOSS (TISSUE AND BONE): I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition.

Initials _____

8. FILLINGS: I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

Initials _____

9. DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of 30 days, there will be additional charges.

Initials _____

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of the dental fees. I agree to pay any attorney's fees, or court costs, that may be incurred to satisfy this obligation.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if Patient is a minor _____ Date _____

NUOVA DENTAL OFFICE

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 IT CAREFULLY.

THIS 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 (04/14/2003), 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, provide such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and in 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 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 of other healthcare provider pending treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provided to you. Healthcare operations: We may use or 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, and certification licensing or credentialing activities.

Our 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. You revocation will not affect any use of 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 responsible inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other 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 the authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials 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 your 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 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 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, health operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in 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, 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 on 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 by using the contact information 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 to 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 the U.S. Department of Health and Human Services.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services Office of Civil Rights
200 Independence Avenue, S.W. Washington, DC 20201
202/619-0257

Toll free: 1/877-696-6775

ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I _____, have received the office's Notice of Privacy Practices.

Signature

Date