EL CERRO DENTAL
Naina Jain, DMD & Gary C. Cappelletti

300 El Cerro Blvd., #C
Danville, CA 94526
(925) 837-8564

PATIENT INFORMATION

This information is necessary for your treatment and the maintenance of your health. It is considered confidential. In order to make an intelligent and comprehensive analysis of your dental condition, it is the policy of this office for each patient to have a thorough examination, including a full survey of dental x-rays and frequently, diagnostic models of your mouth. Please ask the receptionist, if you have any questions.

Name _____ Birthday _____
Residence _____ City _____ Zip _____
Residence Phone _____ Social Security # _____
Employed By _____ Occupation _____
Business Phone _____
Cell Phone _____ Email _____
Spouse _____
Spouse Employed by _____ Occupation _____
Business Phone _____
Cell Phone _____ Email _____
Person Responsible for the Account _____
Name of nearest relative not living with you _____
Address _____ Phone _____
Physician _____ Address _____ Phone _____
Former Dentist _____ Address _____ Phone _____
Whom may we thank for referring you? _____

HEALTH QUESTIONNAIRE

MEDICAL HISTORY:
Do you have, or have you had, any of the following:

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
❑	❑	AIDS	❑	❑	Fainting Spells & Seizures	❑	❑	Respiratory Disease
❑	❑	Anemia	❑	❑	Head Injuries	❑	❑	Rheumatic Fever
❑	❑	Arthritis & Rheumatism	❑	❑	Heart Ailment	❑	❑	Sinus Trouble
❑	❑	Asthma & Hay Fever	❑	❑	Hepatitis, Jaundice or Liver Disease	❑	❑	Stomach Ulcers
❑	❑	Blood Diseases	❑	❑	High Blood Pressure	❑	❑	Stroke
❑	❑	Diabetes	❑	❑	Kidney Disease	❑	❑	Tuberculosis
❑	❑	Epilepsy	❑	❑	Nervous Condition	❑	❑	Tumors or Growths
❑	❑	Excessive Bleeding	❑	❑	Radiation Treatment	❑	❑	Other: _____

1. Do you have any disease, condition or problem no listed above? ..... YES NO
2. Date of last physical examination: _____
3. Are you now under the care of a physician? ..... YES NO
4. Have you every had any serious illness or operation? ..... YES NO
   If so, what? _____
5. Are you taking any drugs or medications? ..... YES NO
   If so, what? _____
6. Are you sensitive or allergic to any drugs (penicillin, Tetracycline, Sulfa Drugs) ..... YES NO
   If so, what? _____
7. Have you had heart surgery? ..... YES NO
8. Do you wear a Cardiac Pacemaker? ..... YES NO
9. (Women) Are you pregnant? ..... YES NO
10. Have you ever had any systemic diseases or infections? ..... YES NO
11. Are you on a special diet? ..... YES NO
12. Are you in good health at this time? ..... YES NO
13. Have you ever suffered: (a) nutritional deficiencies (b) colitis? ..... YES NO
14. Are you taking or have ever taken (a) cortisone (b) steroids? ..... YES NO
15. Have you ever used Fen Phen? ..... YES NO
16. Have you ever had any reaction to local anesthetics? ..... YES NO
17. Do you have any other allergies, including latex products? ..... YES NO
    If so, what? _____

CHIEF COMPLAINT:

Is there any one specific problem or situation involving your teeth or gums that is a particular problem at this time? ..... YES NO

_____

_____

DENTAL HISTORY:

When was your last visit to the dentist? _____

Are you having a dental problem which requires immediate attention? ..... YES NO
Have you ever had any complaints during or after a dental treatment? ..... YES NO
Have you any objection to the use of local anesthetic (novacaine)? ..... YES NO
Are there now any unhealed injuries, inflamed areas, or growths in or around your mouth? ..... YES NO
Have you ever had any periodontal (gum) treatment? ..... YES NO
Have you ever had orthodontic (teeth straightening) treatment? ..... YES NO
Have you ever had full mouth x-rays taken? ..... YES NO
Date of full mouth x-rays? _____

Circle the disease or symptom which pertains to your history:

1. Have you ever had: (a) difficult extraction (b) prolonged bleeding after an extraction (c) dry socket (d) trench mouth (e) pyorrhea (f) bleeding gums?
2. Have you ever suffered with: (a) clicking or popping jaws (b) pain in or near the ear (c) difficulty in opening the mouth (d) sensitive teeth?
3. Do you: (a) grind your teeth (b) clench your teeth (c) awake in the morning with jaws or teeth aching (d) catch food between teeth (e) chew on one side?
4. Do any of the following normal daily activities cause pain: (a) yawning (b) chewing (c) swallowing (d) speaking (e) singing (f) shouting (g) brushing teeth (h) turning head (i) brushing or combing hair (j) hunching shoulders (k) moving the neck?
5. Do your teeth hurt? (a) upper right (b) lower right (c) upper left (d) lower left
6. If you are having pain, is it: (a) dull and constant (b) throbbing (c) occasional (d) reacting to heat (e) reacting to cold?
7. Have you ever had cervical traction? Yes No

TMJ HISTORY:

Do you have difficulty opening your mouth? ..... YES NO
Do you hear noises from the jaw joints? ..... YES NO
Does your jaw get “stuck,” “locked,” or “go out”? ..... YES NO
Do you have pain in or about the ears or cheeks? ..... YES NO
Do you have pain on chewing or yawing or wide opening? ..... YES NO
Does your bite feel uncomfortable or unusual? ..... YES NO
Have you ever had an injury to your jaw, head or neck? ..... YES NO
Have you ever had arthritis? ..... YES NO
Have you previously been treated for a temporomandibular disorder? ..... YES NO
If so, when, how, and by whom? _____

I,_____, authorize this facility to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to this facility. I authorize this facility to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.
I understand it is my responsibilty to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is this facility’s procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals.
We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transcaction.

_____ _____
Patient or Responsible Party Signature Date

I hereby grant authority to Dr. Gary C. Cappelletti to administer premedication or sedation by the inhalation or oral route, or to administer such anesthetic and to perform such procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Patient Signature: _____ Relationship: _____ Date: _____

Dentist Signature: _____ Date: _____

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this faciliy's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- this facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.

X Signature of Patient or Legal Representative Witness .....

Printed Name of Patient or Legal Representative Witness .....

Date: .....

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;
- that this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

X Signature of Individual or Legal Representative Witness ....
.....

Printed Name of Individual or Legal Representative

Witness.....

Date: .....

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____

_____

_____ _____

Privacy Official Date