

# PATIENT REGISTRATION

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## Patient Information

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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address2: \_\_\_\_\_

City: \_\_\_\_\_ FL: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Email: \_\_\_\_\_  I would like to receive correspondences via e-mail

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

What do you do for a living? \_\_\_\_\_

Does your employment cause you stress? Explain \_\_\_\_\_

Rank your stress level on a scale of 1 to 10 (1=least, 10=most) \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

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## Primary Insurance Information

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Name of Policy Holder: \_\_\_\_\_ Policy Holder Birth Date: \_\_\_\_\_

Relationship to Policy Holder:  Self  Spouse  Child  Other

Policy Holder Soc. Sec: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address2: \_\_\_\_\_ Address2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zipcode: \_\_\_\_\_ Zipcode: \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

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# DENTAL HISTORY

**\* Please write "Y" for Yes or "N" for No where necessary \***

Primary reason for this dental appointment:  Examination  Emergency  Consultation

Date of your last dental visit : \_\_\_\_\_ For what? \_\_\_\_\_

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Date of your last dental cleaning \_\_\_\_\_

Do you have a specific dental problem? Describe \_\_\_\_\_

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What kind of dental procedures have you had done in the past? \_\_\_\_\_

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Do you have any sensitive teeth? Which ones? \_\_\_\_\_

Have you ever had a toothache or a fractured tooth? \_\_\_\_\_

Have you ever had peridontal problems? \_\_\_\_\_

Do you like your smile? Why? \_\_\_\_\_

Does food catch between your teeth or do you have areas that are difficult to floss? \_\_\_\_\_

Does loss of teeth tend to run in your family? \_\_\_\_\_

Do you ever have clicking, popping or discomfort in the jaw joint? \_\_\_\_\_ Do you brux or grind? \_\_\_\_\_

Have you ever had Orthodontics (Braces)? \_\_\_\_\_

Have your past experiences in a dental office always been positive? \_\_\_\_\_

Do you smoke or chew do you have any sores or growths in your mouth? Describe \_\_\_\_\_

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Name of previous dentist \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

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# DENTAL HISTORY

continued

\* Please write "Y" for Yes or "N" for No where necessary \*

Have you noticed spots or stains on your teeth that concern you? \_\_\_\_\_

Anything else that concerns you about the appearance of your teeth? \_\_\_\_\_

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If you could change anything about your smile, what would you change? \_\_\_\_\_

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Do you have a denture or partial denture? \_\_\_ How old are they? \_\_\_\_\_ How do you like them? \_\_\_\_\_

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Have you ever required Nitrous Oxide (Laughing Gas) or sedatives for your dental treatment? Describe \_

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Have you ever had an injury to your head & neck? If yes, how long ago and please describe the injury \_\_\_\_\_

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Have you ever been in a car accident? Explain \_\_\_\_\_

Do you have pain in your jaw joints? Explain \_\_\_\_\_

Has your jaw ever locked open or locked shut? \_\_\_\_\_

Are you aware of clenching or grinding your teeth? \_\_\_\_\_

How often do you brush? \_\_\_\_\_ floss? \_\_\_\_\_ use an ultrasonic type toothbrush? \_\_\_\_\_

Is there anything you want the doctor or staff to know about you before you come into the office? \_\_\_\_\_

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## Check Your Level of Bravery



Don't worry...  
we are very gentle

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain:
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:
Have you ever had a serious head or neck injury? Yes No If yes, please explain:
Are you taking any medications, pills, or drugs? Yes No If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain:
Are you on a special diet? Yes No
Do you use tobacco? Yes No If yes, please explain:
Do you use controlled substances? Yes No If yes, please explain:

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics
Other If yes, please explain:

- Do you have, or have you had, any of the following?
AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Recent Weight Loss Yes No
Alzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes No Renal Dialysis Yes No
Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Rheumatic Fever Yes No
Anemia Yes No Easily Winded Yes No Herpes Yes No Rheumatism Yes No
Angina Yes No Emphysema Yes No High Blood Pressure Yes No Scarlet Fever Yes No
Arthritis/Gout Yes No Epilepsy or Seizures Yes No Hives or Rash Yes No Shingles Yes No
Artificial Heart Valve Yes No Excessive Bleeding Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No
Artificial Joint Yes No Excessive Thirst Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No
Asthma Yes No Fainting Spells/Dizziness Yes No Kidney Problems Yes No Spina Bifida Yes No
Blood Disease Yes No Frequent Cough Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No
Blood Transfusion Yes No Frequent Diarrhea Yes No Liver Disease Yes No Stroke Yes No
Breathing Problem Yes No Frequent Headaches Yes No Low Blood Pressure Yes No Swelling of Limbs Yes No
Bruise Easily Yes No Genital Herpes Yes No Lung Disease Yes No Thyroid Disease Yes No
Cancer Yes No Glaucoma Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes No
Chemotherapy Yes No Hay Fever Yes No Osteoperosis Yes No Tuberculosis Yes No
Chest Pains Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes No
Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Parathyroid Disease Yes No Ulcers Yes No
Congenital Heart Disorder Yes No Heart Pace Maker Yes No Psychiatric Care Yes No Yellow Jaundice Yes No
Convulsions Yes No Heart Trouble/Disease Yes No Radiation Treatments Yes No
Have you ever had any serious illness not listed above? Yes No If yes, please explain:

Have you been diagnosed with any medical conditions in the past?
Are you being treated for any medical conditions?
Have you had any hospitalizations in the last 2 years? Describe
Do you have artificial valves in the heart? Have you had any cardiac stents?
Do you have any artificial joints, screws, pins or bolts in any joints or bones?

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**  
**Fine Dentistry of Downtown Orlando**  
**Dr. Aileen Trivedi, D.M.D.**  
429 N. Ferncreek Avenue  
Orlando, FL 32803  
407-898-1621  
drtrivedi@finedentistryorlando.com  
Danny Macaw – Contact Person

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**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.**

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We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

**TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

**USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high

ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

## **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

## **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a

shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

**OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

**COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us using the contact information above.

**FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

**ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of Fine Dentistry of Downtown Orlando's Notice of Privacy Practices.

Patient name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF INFORMATION RELEASE**

IF YOU ALLOW YOUR RECORDS TO BE DISCUSSED OR RELEASED TO ANYONE OTHER THAN YOU PLEASE STATE WHO THAT WOULD BE AND SIGN THAT YOU ACKNOWLEDGE THIS PERMISSION TO TAKE PLACE.

\_\_\_\_\_  
NAME YOU GIVE PERMISSION TO

\_\_\_\_\_  
RELATIONSHIP TO YOU

\_\_\_\_\_  
YOUR SIGNATURE

Fine Dentistry of Downtown Orlando P.A.  
Aileen Trivedi D.M.D  
429 N. Ferncreek Ave  
Orlando, FL 32803  
Office# 407-898-1621  
Fax# 407-895-7280

**WARNING FOR ALL INSURANCE PATIENTS**

We make every attempt to verify your benefits, all plans are not equal!

Responsibility rests with you to make sure we are on your insurance network.

If you have any questions please call your insurance company.

We will not be held responsible for those seen outside of their insurance network.

If you have any questions about insurance, treatment or fees, please do not hesitate to address them with one of our staff members before your scheduled appointment.

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Patient Name

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Date

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Patient Signature