DENTAL REGISTRATION AND HISTORY

(PLEASE PRINT)

Christine Tracy Castro, DMD
Smiles of Cardiff by the Sea
(760) 944-1041

Date ______________________ Home Phone (____) ______________ Cell Phone (____) ______________

PATIENT INFORMATION

Name ______________________________________ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # ______________

Address ______________________ E-mail ______________

City ______________________ State ______ Zip ______

Sex ☐ M ☐ F Age ______ Birthdate ______________ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for ______ years ☐ Minor

Patient Employer/School ______________________ Occupation ______________

Employer/School Address ______________________ Employer/School Phone (____) ______________

Whom may we thank for referring you? ______________________

In case of emergency who should be notified? ______________________ Phone (____) ______________

PRIMARY INSURANCE

Person Responsible for Account ______________________________________ (Last Name / First Name / Middle Initial)

Relation to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (If different from patient's) ______________________ Phone (____) ______________

City ______________________ State ______ Zip ______

Person Responsible Employed by ______________________ Occupation ______________

Business Address ______________________ Business Phone (____) ______________

Insurance Company ______________________

Contract # ______________ Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan ______________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________ Birthdate ______________ Relation to Patient ______________

Address (If different from patient's) ______________________ Phone (____) ______________

City ______________________ State ______ Zip ______

Subscriber Employed by ______________________ Business Phone (____) ______________

Insurance Company ______________________ Soc. Sec. # ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan ______________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ (Name of Insurance Company(ies)) and assign directly to Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________________ Signature of Patient, Parent, Guardian or Personal Representative

______________ Date

______________________________________ Please print name of Patient, Parent, Guardian or Personal Representative

______________ Relationship to Patient

#10512 – © 2004 Medical Arts Press® 1-800-328-2179

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for Today's Visit ______________________ Date of last dental care ______________________

Former Dentist ______________________ Date of last dental X-rays ______________________

Address ____

Check (✓) if you have had problems with any of the following

☐ Bad breath
☐ Bleeding gums
☐ Clicking or popping jaw
☐ Food collection between teeth
☐ Grinding teeth
☐ Loose teeth or broken fillings
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth

How often do you floss? ______________________ How often do you brush? ______________________

MEDICAL HISTORY

Physician's Name ______________________ Date of Last Visit ______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ☐ Yes ☐ No

Have you had any serious illnesses or operations? ______________________ If yes, describe ______________________

Have you ever had a blood transfusion? ☐ Yes ☐ NoIf yes, give approximate dates______________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

____

____

Pharmacy Name ______________________

Phone (_____) ______________________

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Latex______________________
☐ Other______________________
____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ______________________ Signature ______________________

Welcome to Dr. Christine Castro's Dental Office. We are aware that you have a choice of dental offices and we thank you for choosing ours. Our mission is dedicated to providing the personalized, quality dental care in a safe, warm and friendly environment. We strive to treat you with the dignity and respect you deserve while providing courteous, dependable service. We do our best to recognize your personal needs and work to earn your trust.

Financial Policy

Our fees are based on our experience in performing your needed treatment and the quality of the materials we use. We are here to work with you and not let expense prevent you from benefiting from the quality care you desire and need. We are sensitive to the fact that some people may not be able to pay cash for treatment therefore we offer several financial options for your assistance and convenience. These are:

Cash/Checks **Major Credit Cards** **Care Credit (External Financing)**

- A 10 % accounting adjustment is extended when fees are paid in full on the day that procedure appointment is scheduled in cash or check form (excluding Credit Cards or CareCredit and Lending Club transactions).

- 0% Interest payment plans are available through Care Credit. You can apply for low monthly payment plan in the office or online for just a few minutes. No upfront, no annual fees and affordable low monthly payments, OAC.

- There will be a $25.00 charge for any returned checks

- These financial options can be reviewed with our Treatment Coordinator upon presentation of your dental needs and recommended treatments.

Insurance Assistance

Our practice accepts most dental insurance programs (PPOs) used by most employers nationally. The amount your insurance will pay is determined by the contract between your employer and the insurance company. The higher the premium paid by your company, the more generous the fee schedule from which your benefit is calculated.

Although we are not a party to the contractual arrangement between your employer and the insurance company, we do want to help you receive the maximum reimbursement to which you are entitled. At all times you can be confident that we will always provide you with our best services with regard to the limitations imposed by your insurance coverage. **To do otherwise would violate our contract with you - the only contract we feel morally obliged to honor.**

We request that Assignment of Benefits be designated to the office. **Under this circumstance, you are still completely responsible of your account if the insurance company denies payment of your benefits**. Some insurance companies do not accept assignment of benefits and will send payment directly to the insured for services rendered to you. This payment needs to be forwarded to our office with the explanation of benefits (EOB) statement to properly settle your account. **All charges to your account are your full responsibility regardless of insurance payment of otherwise.**

Appointment Cancellation, No Show and Records/X-ray Duplication

We respect and value your time. 24-hour notice is required for cancellation of an appointment. This will allow us to offer the unused time to other patients needing treatment. At our discretion, you may incur a $45 charge in your account for not showing, canceling or rescheduling a requested appointment less than 24 hour notice. We understand that emergencies occur and these situations will be considered before charging your account.

All original x-rays taken in conjunction with diagnosis and treatment are legal property of this office. Request for copies (electronic or print) require your signed consent. A $25.00 charge is required to request copy of the entire dental record. Duplicates may be picked up or mailed to you after 3-5 working days.

______________________________________ ____________

I acknowledge and understand the statements above. Date
Responsible Party

Aviso De La Christine Castro, DMD, Para Las Practicas Privadas

Este aviso describe como su information puede ser utilizada y revelada y como puede usted acceder a esta informacion. Por favor, revisela cuidadosamente.

En la Smiles de Cardiff, siempre hemos mantenido su informacion de salud de forma segura y confidencial. Una nueva ley nos exige que continuemos manteniendo su privacidad, le enviemos este aviso y sigamos los terminos de este aviso.

La ley nos permite que utilicemos o revelemos su informacion de salud a aquellos implicados en su tratamiento. Por ejemplo, una revision de su archivo por un doctor especialista que puede estar involucrado en sus cuidados.

La podemos usar para revelar su informacion de salud para el pago se sus servicios. Por ejemplo, podemos enviar un reporte de su progreso a su de salud.

Podemos usar o revelar su informacion de salud en nuestras operaciones regulares de ciudados de salud. Por ejemplo, alguien denuestro personal, puede salud introducir su informacion en nuestro computador.

Podemos compartir su informacion medica con nuestros asociados de negocios, como un servicio de facturacion. Tenemos un contrato escrito con cada asociado de negocios, que protejan su privicidad.

Podemos usar su informacion para contactarle. Por ejemplo, podemos enviar boletines y otra informacion. Tambien puede que queramos llamarle y recordarle sus citas. Si usted no esta en casa, podemos dejar esta informacion en su contestador automatico o con la persona que responda al telefono.

En caso de emergencia, podemos revelar su informacion de salud a un miembro de la familia o a otra persona responsablede su cuidado.

Podemos revelar parte o toda su informacion de salud cuando esto sea requierdo por la ley.

Si nuestra practica es vendida, su informacion se convertira en propiedad del Nuevo dueno.

Excepto por lo que se describe arriba, esta practica no utilizara o revelara su informacion de dalud sin su previa autorizacion esrita.

Usted tiene el derecho a saber de cualquier uso o revelacion que llevemos a cabo con su informacion de salud, mas alla de los usos normales.

Dado que necesitaremos poneros en contacto con usted de vez en cuando, utilizaremos la direccion o telefono que usted prefiera.

Usted tiene el derecho de transferir copias de su informacion de salud a otra practica. Enviaremos sus archivos por usted.

Usted tiene el derecho de ver y escriir de su informacion de salud, con unas pocas excepciones. Presentenos una solicitud por escrito con respecto a la informacion que desea ver. Si usted tambien quiere una copia de sus registros, puede que le carguemos una tarita razonable por las copias.

Usted tiene ele derecho de pedir una modificacion o cambio de su informacion de salud. Entreguenos su peticion para hacer los cambios por escrito. Si usted desea incluir una declaracion en su archivo, por nos sentiremos complacidos de incluir su declaracion en su archivo. Si estamos de acuerdo en una modificacion o cambio, no eliminaremos ni alteratemos documentos previos, sino que anadiremos nueva informacion.

Usted tiene el derecho de recibir una copia de este aviso.

Si cambamos cualquiera de los detalles de ese aviso, le notificaremos de los cambios pro escrito.

Usted puede presentar una queja con el Departamento de Salud y Servicios Humanos (Department of Health and Human Services), 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. No habra represalias por el hecho de que presente una queja.

Sin embargo, antes de presentar una queja, o para mas informacion o ayuda con respecto a la privacidad de su informacion de salud, por favor pongase en contacto con nuestra Funcionario de Privacidad, Edwin Licup en el (760)944-1041.

Este aviso entra en efecto el 01 de Enerol de 2013.

Rconocimento:

He recibo una copia del aviso de la Smile de Temecula para las Practicas Privadas.

Signatura: ______________________________Pecha:________________________________

Nombre el paciente si parentes o guardian son signing. __________________________________

Christine Castro, DMD Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Smiles of Cardiff by the Sea, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, on of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you, For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who is answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If you change any details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington DC, 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Ed Licup, at 760-944-1041.

This notice goes in effect as of January 01, 2013.

Acknowledgement

I have read and understood Smiles of Cardiff by The Sea Notice of Privacy Practices.

Signature: ________________________________ Date:________________________________

Name of Patient if signing as a parent or guardian: ____________________________________

CHRISTINE CASTRO, D.M.D.

CARDIFF BY THE SEA

List of Current Prescribed and Over the Counter Medications

Name: ________________________________ **Date:** ________________

DOB: ________________________________

Medication	Amount/Dosage	Instructions	Reason for Taking

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: ____

Date: ____

Doctor's Signature/Date: ____

CHRISTINE CASTRO, DMD, CARDIFF, CA

(PLEASE PROVIDE YOUR CONTACT INFORMATION)

DATE: ___________________________

PATIENT'S NAME : ____

PREFERRED (NICKNAME) : ____

HOME ADDRESS : ____

____

HOME PHONE # : ____

WORK PHONE# : ____

CELL PHONE# : ____

(Text Messaging Will Be Available To Contact You)

Whom may we thank for referring you? ____

E-MAIL ADDRESS : ____

EMERGENCY CONTACT PERSON: ____

RELATION TO PATIENT : ____

CONTACT NUMBER: WORK: ___________________ **CELL:** ____________________

FACEBOOK.COM/SMILES OF CARDIFF AND JOIN IN "LIKING" US