

# WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

## 1

### ABOUT YOU

Today's Date: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**Name:** \_\_\_\_\_  
Last First Mi Mr Mrs Ms Dr

I prefer to be called: \_\_\_\_\_ ☐ Male ☐ Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
Apt/Condo # \_\_\_\_\_

City State Zip  
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (\_\_\_\_) \_\_\_\_\_ Pager / Cell #: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ DL #: \_\_\_\_\_

**Employer:** \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

Whom may we Thank for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous / Present Dentist: \_\_\_\_\_  
(Please Circle)

Last Visit Date: \_\_\_\_\_

## 2

### SPOUSE INFORMATION

His / Her Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ SS #: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ DL #: \_\_\_\_\_

**Person Responsible for Account:** \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

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

Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

## 3

### INSURANCE

#### Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

#### Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_) \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's ID #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

#### Neighbor or Relative not living with you (for emergency).

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Wk #: (\_\_\_\_) \_\_\_\_\_ Hm #: (\_\_\_\_) \_\_\_\_\_

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

City State Zip

## 4

### MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: \_\_\_\_\_

CONTINUED ON BACK



**Your current physical health is:** ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: \_\_\_\_\_

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

**For Women:** Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: \_\_\_\_\_

Are you nursing? ☐ Yes ☐ No

**Have you ever had any of the following diseases or medical problems**

<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Herpes / Fever Blisters
<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Lupus
<input type="checkbox"/> Y <input type="checkbox"/> N Colitis	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis / Paget's Disease
<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker
<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures
<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Shingles
<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits
<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Stroke
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)
<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

**Are you allergic to any of the following?**

<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Latex	<input type="checkbox"/> Y <input type="checkbox"/> N Other
<input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

**Why have you come to the dentist today?** \_\_\_\_\_

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

**Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?** ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? \_\_\_\_\_ a day do you brush? \_\_\_\_\_

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? \_\_\_\_\_

Are your teeth sensitive to heat, cold, or anything else? \_\_\_\_\_

Have you lost any teeth? ☐ Yes ☐ No If yes, why? \_\_\_\_\_

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 confidence and it is my responsibility to inform this 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 \_\_\_\_\_

**Payment is due in full at the time of treatment**  
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

**OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Doctor's Comments:** \_\_\_\_\_

#### MEDICAL HISTORY UPDATE

I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions.

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

I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions.

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

I have read my medical history dated \_\_\_\_\_ and confirmed that it states past and present medical conditions.

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

Alec C. Nelson, D.D.S.

# 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.

THE 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 04/04/03, 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, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and 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 listed 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 or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and 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, certification, licensing or credentialing activities.

**Your 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. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a 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 reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar 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 to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official 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 you 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 a flat fee of \$20.00 for staff time to 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 listed 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, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** 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 or 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 about 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 using the contact information listed 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 with 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 us or with the U.S. Department of Health and Human Services.

**Contact Officer:** Dr. Alec C. Nelson

**Telephone:** 707-546-2829 **Fax:** 707-546-2778

**Address:** 855 Fountaingrove Parkway, Suite 100, Santa Rosa CA 95403



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Alec C. Nelson D.M.D

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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## For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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**Alec C. Nelson, D.D.S.**

**DENTAL MATERIALS FACT SHEET**

By far, the most commonly used materials in restorative dentistry are gold, porcelain, composites, and amalgam. Each has its own advantages and disadvantages, risks and benefits. Each restorative material contains some ingredients, which may preclude its use on some patients who have sensitivities, allergies, or other special health care needs. Information contained in this fact sheet is intended to encourage discussion between the patient and dentist in the selection of dental materials best suited to the patient's dental health. It is not intended to be a complete guide to dental materials science.

Dental amalgam, used as a primary dental restorative material for over 150 years, is composed of numerous metals mixed together in varying percentages (43% to 54% liquid mercury and 46% to 57% alloy powder). The mercury component allows for the other metals in the alloy powder (largely silver, copper and tin) to form the "amalgam". Although elemental mercury has been known to be a toxic substance, it was long believed that once it become bounded to the metals in the amalgam. It loses its toxicity. Recent research, however, has shown that minute amounts of free mercury can escape from amalgam fillings and be absorbed by the body during placement, adjustment, or by vigorous chewing. The preponderance of scientific evidence, to date, fails to show that exposure to mercury from amalgam restoration poses a health risk, except for a small number of allergic and/or sensitive patients.

Direct composite fillings have become an acceptable alternative for dental alternative for dental amalgam when used appropriately. Composites are comprised of numerous elements such as dimethacrylates, bisphenyl compounds and beryllium. Some elements contained in composites have been determined to be catatonic and carcinogenic. Since the use of composites as a restorative material is relatively new, scientific research has not yet determined the long term benefits or risks involved. However, composites are gaining wider acceptance as a restorative material.

In contrast to the above restorative materials, research has uncovered no health hazards from cast gold or porcelain restorative materials (aside from allergies). However, some non-precious alloys used in place of gold or porcelain have been known to cause sensitivities or allergic reaction in small percentage of patients. Patients should be aware of the risks when choosing these options.

Restorative materials such as composite and amalgam fillings and crown, orthodontic appliances such as brackets and wires, and other materials used in dental treatment contain chemicals known to the State of California to cause cancer, birth defects, or other reproductive harm.

I have read and understand this information.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_