Herrera
FAMILY DENTAL

PATIENT REGISTRATION FORM [*FORMA DE INFORMACION DE NUEVO PACIENTE*]

Today's Date [*Fecha de hoy*]: _____/_____/_____
Patient Name [*Nombre del paciente*]: _____
Preferred Name [*Nombre preferido*]:_____
Birthdate [*Fecha de nacimiento del Paciente*]: _____/_____/_____ ☐ **Male** [*Masculino*] ☐ **Female** [*Femenino*]
☐ **Married** [*Casado(a)*] ☐ **Single** [*Soltero(a)*] ☐ **Child** [*Niño(a)*] ☐ **Other** [*Otro*]
Address [*Domicillio*]:_____
City [*Ciudad*]: _____**State** [*Estado*]: _____**Zip Code** [*Código Postal*]: _____
Social Security # or ID # [*Número de seguro social del Paciente o ID#*]: _____
Home Phone [*Teléfono de casa*]: (_____) _____ **Cellphone** [*Teléfono cellular*]: (_____) _____
Work Phone [*Teléfono del trabajo*]: (_____) _____
Email Address [*Dirección de correo electrónico*]:_____

Name of Parent or Responsible Party [*Nombre de los Padres del Paciente*]: _____
Address of Parent or Responsible Party (if not the same) [*Domicillio del os Padres (Sino es el mismo)*]:
_____
City [*Ciudad*]: _____ **State** [*Estado*]: _____ **Zip Code** [*Código Postal*]: _____
Home Phone [*Teléfono de casa*]: (_____) _____ **Cellphone** [*Teléfono cellular*]: (_____) _____
Work Phone [*Teléfono del trabajo*]: (_____) _____
Employer [*Empleador*]:_____ **Occupation** [*Ocupación*]:_____
Parent Date of Birth [*Fecha de nacimiento de los Padres*]: _____/_____/_____

First Insurance [*Seguro Primario*]: _____**Group #** [*Número de grupo*]: _____
Name of Policy Holder[*Nombre de suscriptor*]: _____
Birthdate [*Fecha de nacimiento*]: _____/_____/_____ **Employer** [*Empleador*]:_____
Relationship to patient [*Relación con el paciente*]:_____
ID # or Social Security # [*ID # o Número de Seguro Social*]: _____
Second Insurance [*Seguro segundo*]: _____**Group #** [*Número de grupo*]: _____
Name of Policy Holder[*Nombre desuscriptor*]: _____
Birthdate [*Fecha de nacimiento*]: _____/_____/_____ **Employer** [*Empleador*]:_____
Relationship to patient [*Relación con el paciente*] :_____
ID # or Social Security # [*ID # o Número de Seguro Social*]: _____
I hereby authorize payment to Herrera Family Dental of benefits payable to me under the above policy. I also authorize Herrera Family Dental to release to the above insurance needed to process claims. I understand that I am financially responsible for all charges whether or not paid by insurance. [Autorizo el pago a Herrera Family Dental de todos los beneficios del seguro arriba mencionado por mis servicios. También autorizo a Herrera Family Dental a divulger dicha information al seguro arriba mencionado por lo que se necesite para procesar reclamos. Entiendo que soy financieramente responsable de todos los cargos ya sea que los pague o no el seguro.

Signature of Patient or Responsible Party [Firma del paciente o persona responsable]:

_____ _____ _____ Date [Fecha]:_____/_____/_____

1300 S. Lamb Blvd., Ste 400 Las Vegas, NV 89104 * T(702)780-7660 * F(702)780-7669

Health History [*Historia de la Salud*]

Do you have or have you ever had any of the following? Please check ALL that apply:
***[¿Tiene o ha tenido alguna de las siguientes enfermedades? Por favor marcar TODAS las que corresponden]*:**

AIDS-HIV [*SIDA-VIH*]	☐ YES ☐ NO	Anemia	☐ YES ☐ NO
Arthritis [*Artritis*]	☐ YES ☐ NO	Asthma [*Asma*]	☐ YES ☐ NO
Artificial Joints [*Articulaciones Artificiales*]		☐ YES ☐ NO	
Bisphosphonate Medication [*Medicamento Bisfosfonato*]		☐ YES ☐ NO	
Blood Disease [*Enfermedad de la Sangre*]		☐ YES ☐ NO	
Bloody Sputum [*Esputo Sanguinolento*]		☐ YES ☐ NO	
Breast Implants [*Implantes Mamarios*]		☐ YES ☐ NO	
Cancer [*Cáncer*]	☐ YES ☐ NO	Chest Pain [*Dolor en el Pecho*]	☐ YES ☐ NO
Chronic Cough, > 3 weeks [*Tos Cronica, > 3 semanas*]		☐ YES ☐ NO	
Diabetes	☐ YES ☐ NO	Dizziness [*Mareo*]	☐ YES ☐ NO
Epilepsy [*Epilepsia*]	☐ YES ☐ NO	Emphysema [*Enfisema*]	☐ YES ☐ NO
Excessive Bleeding [*Sangrado Excesivo*]		☐ YES ☐ NO	
Fainting [*Desmayos*]	☐ YES ☐ NO	Fatigue [*Fatiga*]	☐ YES ☐ NO
Glaucoma	☐ YES ☐ NO	Growths [*Crecimientos]*	☐ YES ☐ NO
Hay Fever [*Fiebre de Heno*]	☐ YES ☐ NO	Head Injury [*Lesion en la Cabeza*]	☐ YES ☐ NO
Heart Disease [*Enfermedades del Corazón*]		☐ YES ☐ NO	
Heart Murmur [*Soplo Cardiaco*]		☐ YES ☐ NO	
Hemoptysis	☐ YES ☐ NO	Hepatitis Type [*Tipo*____]	☐ YES ☐ NO
High Blood Pressure [*Presión Arterial Alta*]		☐ YES ☐ NO	
Hoarseness [*Ronquera*]	☐ YES ☐ NO	Jaundice [*Ictericia*]	☐ YES ☐ NO
Kidney Disease [*Enfermedad de Riñón*]		☐ YES ☐ NO	
Liver Disease [*Enfermedad Hepatica*]		☐ YES ☐ NO	
Loss Appetite [*Pérdida del Apetito*]		☐ YES ☐ NO	
Mental Disorders [*Trastornos Mentales*]		☐ YES ☐ NO	
Mitral Valve Prolapse [*Prolapso de Valvula Mitral*]		☐ YES ☐ NO	
Nervous Disorders [*Trastornos Nerviosos*]		☐ YES ☐ NO	
Night Sweats [*Sudores Nocturnos*]		☐ YES ☐ NO	
Pacemaker [*Marcapasos*]		☐ YES ☐ NO	
Prosthetic Heart Valve [*Valvula de Corazon Prostetica*]		☐ YES ☐ NO	
Radiation Treatment [*Tratamiento de Radiacion*]		☐ YES ☐ NO	
Respiratory Problems [*Problemas Respiratorios*]		☐ YES ☐ NO	
Rheumatic Fever [*Fiebre Reumatica*]		☐ YES ☐ NO	
Sexually Transmitted Diseases [*Enfermedades de Transmision Sexual*]			☐ YES ☐ NO
Sinus Problems [*Problemas de Sinusitis*]		☐ YES ☐ NO	
Stomach Problems [*Problemas del Estomago*]		☐ YES ☐ NO	
Stroke [*Embolia*]	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Tumors [*Tumores*]	☐ YES ☐ NO	Ulcers [*Ulceras*]	☐ YES ☐ NO
Unexplained Weight Loss [*Perdida de Pesoinexplicable*]		☐ YES ☐ NO	

Others [*Otro*]: _____

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Herrera FAMILY DENTAL

PATIENT REGISTRATION FORM [*FORMA DE INFORMACION DE NUEVO PACIENTE*]

Are you now under the care of a physician? [*¿Está bajo el cuidado de un medico en este momento*?] ☐ YES ☐ NO
If "YES", please explain [*Si la respuesta es "Sí", por favor explique*]: _____
Name of Physician [*Nombre del Medico*]: _____
Phone # [*Número de teléfono*]: (_____) _____
What, if any, medications are you taking at this time? [*¿Si esta tomando medicamentos en este momento, cuales son*?]
_____
_____

(For WOMEN) Are you pregnant? [(*Para las MUJERES) ¿Esta usted embarazada*?] ☐ YES ☐ NO
If "YES", expected due date [*Si la respuesta es "Sí", cual es la fecha del parto*]: _____/_____/_____
Are you using birth control pills?[*Tomando piladoras anticonceptivas*?] ☐ YES ☐ NO
Are you nursing?[*Amamantando?]* ☐ YES ☐ NO

Do you use controlled substances ?[*Usa substances reguladas?*]: ☐ YES ☐ NO

Are you taking or have taken bisphosphonates for osteoporosis or Paget's Disease? [*Está tomando o ha tomado un agente antirresortivo debido a osteoporosis o a enfermedad de Paget?]:* ☐ YES ☐ NO

Are you allergic to any of the following? [¿Es usted alérgico a cualquiera de los siguientes?]

☐ **NONE [*Ninguno*]**

☐ Anesthetic [*Anestesia*] Reaction [*Reacción*]: _____
Severity [*Gravedad*]: ☐Unknown [*Desconocido*] ☐Mild [*Leve*] ☐Moderate [*Moderado*] ☐Severe [*Grave*]
☐Codeine [*Co*deina] Reaction [*Reacción*]: _____
Severity [*Gravedad*]: ☐Unknown [*Desconocido*] ☐Mild [*Leve*] ☐Moderate [*Moderado*] ☐Severe [*Grave*]
☐Erythromycin [*Eritromicina*] Reaction [*Reacción*]: _____
Severity [*Gravedad*]: ☐Unknown [*Desconocido*] ☐Mild [*Leve*] ☐Moderate [*Moderado*] ☐Severe [*Grave*]
☐Latex [*Látex*] Reaction [*Reacción*]: _____
Severity [*Gravedad*]: ☐Unknown [*Desconocido*] ☐Mild [*Leve*] ☐Moderate [*Moderado*] ☐Severe [*Grave*]
☐Penicillin [*Penicillina*] Reaction [*Reacción*]: _____
Severity [*Gravedad*]: ☐Unknown [*Desconocido*] ☐Mild [*Leve*] ☐Moderate [*Moderado*] ☐Severe [*Grave*]
☐Metals[Metales] Reaction [*Reacción*]: _____
Severity [Gravedad]: ☐Unknown [*Desconocido*] ☐Mild [*Leve*] ☐Moderate [*Moderado*] ☐Severe [*Grave*]
☐Sulfa Reaction [*Reacción*]: _____
Severity [Gravedad]: ☐Unknown [*Desconocido*] ☐Mild [*Leve*] ☐Moderate [*Moderado*] ☐Severe [*Grave*]
☐Other [*Otro*]: _____ Reaction [*Reacción*]: _____
Severity [*Gravedad*]: ☐Unknown [*Desconocido*] ☐Mild [*Leve*] ☐Moderate [*Moderado*] ☐Severe [*Grave*]

Do you smoke or use chewing tobacco? [*¿Fuma o mastica tabaco*?] ☐ YES ☐ NO
If "YES", how often and for how long? [*¿Sí es un "Sí" con que frecuencia y cuanto tiempo tiene haciendolo*?]
_____

In case of an emergency, whom shall we call? [*¿En caso de emergencia, a quién podemos llamar*?]
Name [*Nombre*]: _____ **Relationship** [*Relación*]: _____
Phone # [*Número de teléfono*]: (_____) _____

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Dental History *[Historia Odontológico]*

Please check any of the following problems that apply to you [*Por favor marque unicamente los que le corresponden*]:

- ☐ Bad breath or bad taste in your mouth [*Mal aliento o mal sabor de boca*]
- ☐ Bleeding, swollen or irritated gums [*Sangrado, encias irritadas o inflamadas*]
- ☐ Grinding or clenching teeth [*Rechina sus dientes*]
- ☐ Headaches, earaches or neck pain [*Dolores de cabeza, dolor de oidos o dolor de cuello*]
- ☐ Jaw joint pain [*Dolor en las articulaciones de la quijada/mandibular*]
- ☐ Loose or shifting teeth [*Dientes flojos o moviendeode posición*]
- ☐ Teeth or fillings breaking [*Dientes o rellenos fracturandose*]
- ☐ Tooth pain or discomfort when chewing [*Dolor de dientes o molestias al masticar*]
- ☐ Sensitivity (hot, cold, and sweet) [Sensibilidad a caliente, frio y dulce]
- ☐ Do you snore? [*¿Usted ronca*?] ☐ YES ☐ NO
- ☐ Do you have Sleep Apnea? [*¿Tiene usted Apnea del sueño*?] ☐ YES ☐ NO
- ☐ Do you constantly feel tired even after a full night of sleep? [*¿Se siente cansado (a) constantemente aun despues de haber dormido toda la noche*?] ☐ YES ☐ NO

Do you or have you had any of the following? [*¿Han tenido usted o usted alguno de los siguientes*?]

- ☐ Dentures [*Dentaduras postizas*]
- ☐ Braces [*Frenillos (frenos)*]
- ☐ Partial dentures [*Dentaduras postizas parciales*]
- ☐ Periodontal (gum) disease [*Inflamacion de las encias*]

Please share the following dates [*Por favor indique las siguientas fechas*]:

Your last dental cleaning [*Ultima limpieza dental*]: _____/_____/_____

Your last oral cancer screening [*Ultimo examen de cancer oral*]: _____/_____/_____

Your last complete X-rays [*Ultimas radiografias*]: _____/_____/_____]

How often do you brush? [*¿Con que frequencia se cepilla los dientes*?] _____

How often do you floss? [*¿Con que frecuencia usa el hilo dental*?] _____

Reason For Today's visit?[*Motivo de la consulta de hoy?***]**:_____

How do you feel about your smile?[*Comó se sientecon susonrisa?]***:_____

To the best of my knowledge, all of the preceding answers and information provided in this form is true and correct. I will be responsible to inform the doctor if there is any change in my health at my next appointment. [Al mejor de mi conocimiento, todas las respuestas precedentes e información proporcionada en esta forma son verdaderas y correctas. Soy responsable de informar al médico si hay algún cambio en mi salud para mi próxima cita.]

Signature of Patient or Responsible Party [Firma del paciente o persona responsable]: _____

Date [Fecha]: _____/_____/_____

Doctor Signature [Firma del doctor]: _____

Date [Fecha]: _____/_____/_____

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NOTICE OF PRIVACY PRACTICES

OUR LEGAL DUTY

We are required by 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 that are described in this Notice and will remain in the terms of this Notice 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 changes. Before we make a significant change in our privacy practices, we will change the Notice at any time. For more information about our privacy practices, or additional copies of Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may 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 providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provided 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 professional, 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 my revoke it in writing at any time. Your revocation will not affect any use of 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 with written release on our Information Sharing Consent form.

Persons Involved in Care: We may use or disclose health information to notice, 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 persons involvement in your healthcare. We will also use our professional 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

Required by Law: We will use of disclose your health information when we are required 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.

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 intelligence, counterintelligence and other nation security activities. We may disclose to a 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 voice mail messages, postcard, letter, text messages and/or e-mails).

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 practically dose, you may also request access by sending us a letter to the address at the end of this Notice. 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 of Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment or healthcare operations and certain other activities, for the last 6 years.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternation means or to alternative locations. (Must make your request in writing). Your request must specify the alternative means or location.

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 received this Notice on our Website 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/concerns, please contact using the information provided at the bottom of this notice. 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 locations. You may complain to us using the contact information listed at the end of this notice. You may submit a written complaint to the U.S Department of Health and Human services. We support your right to 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.

HERRERA FAMILY DENTAL
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Las Vegas, NV 89104
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HerreraFamilyDental@gmail.com
www.HerreraFamilyDental.com

ACKNOWLEDGEMENT OF RECEIPT / REVIEW OF NOTICE OF PRIVACY PRACTICES

Herrera
FAMILY DENTAL

I, _____, have received / reviewed a copy of Herrera Family Dental's Notice of Privacy Practices.

_____ _____
Signature Date

For Dependents Only (patients under the age of 18):

_____ _____
Print Name of Dependent Date

_____
Signature of Responsible Party

FOR OFFICE USE ONLY

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

_____Individual refused to sign
_____Communication barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
_____Other_____

_____ _____
Staff Signature Date

Herrera
FAMILY DENTAL

Information Sharing Consent Form

I, _____, give my permission to share information concerning:

- My dental treatment
- The cost and financial arrangements for my dental treatment
- My personal health information
- Other: _____

I give permission to share the above noted information with;

- My spouse (name) _____
- My parent(s) (names) _____
- My adult child or children (names) _____
- Other _____

I, _____, **DO NOT** give my permission to share **ANY** information regarding my treatment, financial arrangements or personal information with the exceptions of what is outlined in the Notice of Privacy Practices.

Signature: _____

Date: _____