PATIENT REGISTRATION

IF THIS APPOINTMENT IS FOR YOU, START HERE.

DATE			
LAST NAME	FIRST		MI
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		WORK NO.	
CELL PHONE NO.		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD, START HERE.

DATE			
LAST NAME	FIRST		MI
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX.

GETTING TO KNOW YOU

PERSON TO CONTACT FOR EMERGENCY	RELATIONSHIP
HOME PHONE NO.	
PHARMACY NAME	PHONE NO.

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

SECONDARY CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	

HAVE YOU OR A CLOSE FAMILY MEMBER BEEN SEEN AT OUR OFFICE IN THE PAST?

YES	NO
IF YES, WHAT IS THEIR NAME?	

1. I hereby authorize doctor or designated staff to take x-rays, cone beam ct-scan, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (patient name)_____'s dental needs. I understand that if a cone beam ct-scan is taken, I have the option to have the scan forwarded to a board-certified oral and maxillofacial radiologist* for a complete reading of any presence of pathology in the medically related anatomical structures which may be seen in the images and data. I understand that should I opt not to have my cone beam ct-scan reviewed by a board-certified oral and maxillofacial radiologist, medical conditions beyond the scope of dentistry may not be diagnosed.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, other medications, and the application of the time release antibiotic (Arestin) as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I understand that if for any reason I am unable to keep my scheduled appointment(s), I am required to make any appointment changes at least 48 hours in advance. I understand that failure to provide 48 hours advance notice may result in a $25.00 failed appointment fee that will be due prior to my next appointment. I understand that missed or cancelled appointments could result in the need for additional periodontal or implant treatment and expenses.
5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of services unless other arrangements have been made. 1-1 ½ % late charge (18% APR) may be added to my account for all unpaid balances.

CONSENT FOR TREATMENT

Patient/Responsible Party_____Date_____Witness_____

*Additional fees may apply.

PATIENT NAME
REFERRED BY

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care, please complete these medical and dental history forms. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit: _____ **Last Dental Hygiene Visit:** _____ **Last Full Mouth X-rays:** _____

What was done at your last dental visit? _____

_____

Have you ever had **periodontal gum treatment?** _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, mouthwash, etc.) _____

Do you have any dental problems now? ..... Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters, or any other oral lesions?	Yes	No

Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have a tired jaw, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Do you currently wear a full/partial denture?	Yes	No

How long have you had your full/partial denture?

_____

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches, or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth, all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

_____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know?..... Yes No

If yes, please describe:

_____

_____

_____

_____

PATIENT NAME	HOW SHOULD WE ADDRESS YOU?
MEDICAL ALERT	

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name: _____ Phone: _____
   Address: _____ City: _____ State: _____ Zip: _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs, or pills now? ..... Yes No
   If yes, please list name and dosage _____
   _____
4. Have you ever taken/do you take bisphosphonates (ie Fosamax)? ..... Yes No
5. Are you aware of having any allergic (or adverse) reaction to any medication or substance?
6. If yes, please list: _____
7. Have you been a patient in the hospital during the past five years? ..... Yes No
8. Indicate which of the following you have had, or have at the present. **Circle "Yes" or "No" to each item.**

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, ect)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

1. Are you currently taking any of the following? **Circle "Yes" or "No" to each item.**

Flax	Yes	No	Garlic	Yes	No	Energy Drinks	Yes	No
Krill Oil	Yes	No	Ginger	Yes	No	Aspirin	Yes	No
Vitamin E	Yes	No	Ginseng	Yes	No	Ibuprofen	Yes	No
Ginkgo	Yes	No	Green Tea	Yes	No	Glucosamine	Yes	No
						Fish Oil	Yes	No

2. Do you smoke? If so, how much? ..... Yes No
3. Have you had abnormal bleeding associated with extractions, surgery, injury or menstruation? ..... Yes No
4. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
5. **Women:** Are you: **Pregnant?** Yes,_____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature_____ Date_____

History Review

D.D.S. Signature:_____ **Date**_____

Identafi

CONSENT FORM FOR ORAL CANCER SCREENING

In our practice, as your healthcare provider, we seek to provide you access to the newest and most effective scientific screening and treatment. In 2009 the Star Dental system was introduced. This multispectral medical device greatly enhances our ability to find early signs of cancer and dysplasia in the mouth. Historically our practice has used white light in examination for oral cancer. The use of narrow band violet light and green-amber reflected light helps us detect in the oral tissue various problems including cancer lesions and dysplasia.

Early detection of oral cancer is important to being able to provide early treatment and avoidance of the problems which arise from late stage detection of oral cancer. We encourage you to discuss with us your questions related to detection of oral cancer.

The Oral Cancer Foundation advises that one American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors, but up to 75% of oral cancer victims have no such lifestyle risk factors. Recently scientists have established a connection between HPV viral infection in the mouth and the occurrence of oral cancer. This screening is non-invasive and the test is simple, painless, and takes less than 2 minutes.

YES. I request that the clinician perform the Star Dental Identafi examination. I accept financial responsibility for this examination. The fee is $26.00

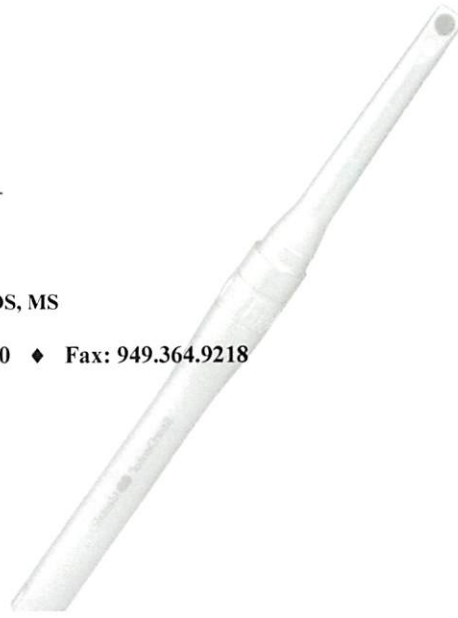
Print Name: _____

Signature: _____Date:_____

No. I would prefer not to have this examination at this time.

Print Name: _____

Signature: _____Date:_____



Ajay B. Setya DDS, MSD **Robert C. Hirst DDS, MS**

27871 Medical Center Road ♦ Suite 260♦ Mission Viejo, CA 92691♦ 949.364.2850 ♦ Fax: 949.364.9218

www.drsetya.com

AJAY B. SETYA, DDS, MSD, Inc.
ROBERT C. HIRST, DDS, MS

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 04/14/03, 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 health care 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).

NOTE: The above-referenced use and disclosure of health information includes, both, written and electronic mediums.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. In addition, you have the right to receive such requested health information within a 2-week period of time (from the initial request date).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 $0.25 for each page, $25.00 per hour for staff time to locate and 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: Gaylee Kraffert
Telephone: (949)364-2850
Email: GR8GUMS@yahoo.com
Address: 27871 Medical Center Road, Suite 260
Mission Viejo, California 92691

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

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

_____ _____
Signature Date

I, _____, hereby authorize Dr. Ajay B. Setya, Dr. Robert C. Hirst, and their staff to contact me to discuss upcoming appointments, recommended treatment, dental insurance inquiries, and/or my account in the following means:

☐ Telephone /Voicemail ☐ Messages Left with Family Members ☐ Email ☐ US Mail

OFFICE USE ONLY

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. ☐ Communication barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement. ☐ Other: _____
_____
_____