Time 1:59 PM

NEWPORT DENTAL SPECIALTIES

Date 3/18/2025

Eaglesoft Medical History USE

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:

X

Date:_____

PREMED

Do you require Antibiotics for Routine dental care? Name of Antibiotic ◯ Yes ◯ No If yes

TIME 11:16 AM

DATE 3/18/2025

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

WELCOME TO OUR DENTAL GROUP

We are happy that you have chosen our group as your dental health provider. The dentist and staff are looking forward to a long healthful relationship with all or our patients.

Our primary concern is your oral health and dental needs; we will strive to provide you with the best quality a professional care that you desire and deserve.

In order to provide timely appointments for all patients, we ask that you please cancel an appointment which you have scheduled and that you are unable to keep, by at least 24 hours before that appointment time. This will enable us to provide that valuable time for another patient and/or an emergency. In fairness to all, a charge of $5.00 per 15 minutes of scheduled time will be billed if your appointment is not cancelled. We record the cancellation/broken appointments in your medical legal records.

Naturally the cost of dental care is a concern to all patients. It is customary to have the patient's share or co-payment paid as the service is rendered unless special arrangements have been discussed and agreed upon by the office manager. In order to keep our fees at the lowest reasonable levels possible, we must have a precise and just payment procedures. While only a small minority of our patients fall into the following category, we must inform you that returned checks and balances older that 30 days may be subject to additional collection fees and late payment fee 1 ½ % per month to any balance owed, in the event of default to pay, reasonable collection charges and/or attorney fees will be added as provided by law.

Your dental coverage is a contract between you, your employer and the Insurance Company. We are not a part of that contract. Not all services are a covered benefit in all contracts. Some Insurance companies arbitrarily select certain dental services they do not cover. No special letters or words to them will change that coverage. If you request, we will give you good faith estimate of charges after your examination. Those estimates are subject to change if you decide on a different course of treatment and use of different materials, or a biomechanical need encountered during the treatment phase. The estimate is not a guarantee of the price. It is your responsibility to know your insurance coverage, not ours. There are thousands of policies and payment schedules. We cannot know precisely what you or your employer has purchased. You are personally responsible for the entire fee for professional services rendered.

If you have any questions regarding your dental care, privacy rights, or any other needs that we should know, please feel free to speak to your dentist or the office management regarding you concern. Remember we want to help and encourage your participation in your good oral health goals.

By signing this form you are allowing Newport Dental Specialties to bill and receive insurance payment from your dental insurance if you have insurance. If you have no insurance full payment is due at the time of service.

Thank you, and welcome to our dental group.

Patient's signature_____ Date_____

NEWPORT DENTAL SPECIALTIES

1401 AVOCADO AVE SUITE 404 NEWPORT BEACH, CA 92660

OFFICE: 949-640-0921

THIS NOTICE DESCRIBES HOW DENTAL AND 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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YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

We are required by law to maintain the privacy of your protected health information ("PHI"), to provide you with this Notice of Privacy Practices, to follow the terms of this

Notice currently in effect, and to notify you if a breach of your unsecured PHI occurs.

Protected Health Information includes information that identifies you and relates to your past, present, or future physical or mental health condition, the provision of health care

to you, or payment for that care.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment: We may use and disclose your health information to provide, coordinate, or manage your dental care. This includes sharing information with dentists,

hygienists, dental specialists, laboratories, or other healthcare providers involved in your treatment.

2. Payment: We may use and disclose your health information to bill and collect payment from insurance companies, dental benefit plans, or other responsible parties.

3. Health Care Operations: We may use and disclose your health information for practice operations, including quality assessment, staff training, licensing, audits,

accreditation, business planning, and administrative purposes.

OTHER USES AND DISCLOSURES PERMITTED OR REQUIRED BY LAW.

We may disclose your health information without your authorization in the following situations:

- As required by federal, state, or local law
- For public health activities
- For health oversight activities such as audits or investigations
- In response to a court order, subpoena, or lawful request
- For law enforcement purposes
- To prevent or lessen a serious threat to health or safety
- For workers' compensation or similar programs

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not use or disclose your health information for purposes other than those described in this Notice unless you provide written authorization. This includes:

- Marketing purposes
- Sale of your health information

You may revoke your authorization at any time in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

• Get a Copy of Your Records: You may inspect or request a copy of your dental and billing records. We will provide access within 30 days as required by law.

• Request Corrections: You may request an amendment if you believe your health information is incorrect or incomplete.

• Request Confidential Communications: You may request that we contact you in a specific way or at a specific location.

• Request Restrictions: You may request limits on how we use or disclose your information. We are not required to agree to all requests.

• Receive a List of Disclosures: You may request an accounting of certain disclosures of your health information.

• Get a Paper Copy of This Notice: You may request a paper copy of this Notice at any time, even if you agreed to receive it electronically.

• File a Complaint: You may file a complaint if you believe your privacy rights have been violated. You may file a complaint with our office or with the U.S.

Department of Health and Human Services. You will not be retaliated against for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and make the revised notice effective for all health information we maintain. Updated notices will be available in our office and on our

website.

CONTACT INFORMATION

If you have questions about this Notice or wish to exercise your rights, please contact:

Privacy Officer: Kristy M.

Dental Office Name: Newport Center Dental Group

Phone: (949) 640-1122

Address: 1401 Avocado Ave., Suite 404, Newport Beach, CA 92660

You may also contact:

U.S. Department of Health and Human Services

Office for Civil Rights

1-877-696-6775

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient Name: _____

Signature: _____

Date: _____