The Dental Extraction Clinic

3560 Fairmount Ave. Suite B San Diego, CA 92105
619-877-0124
Office@TheExtractionClinic.com

**PRE-OPERATIVE INSTRUCTIONS FOR DENTAL SURGERY**

*****PLEASE READ FORMS CAREFULLY. COMPLETE ALL FORMS AND BRING THEM TO YOUR DENTAL APPOINTMENT*****

1. If you have any questions or concerns about the surgery, please contact us at 619-877-0124 or office@TheExtractionClinic.com

2. The Dentist will be reviewing your medical history with you immediately prior to surgery. Please make sure you are familiar with all medications (name and dosage) that you are taking. If your medical history is relatively complicated, we may require a consultation with your physician prior to surgery.

3. Patients who are minors (under 18 years of age) must have a legal guardian present to both fill out the forms and to sign the consent forms.

4. It is strongly recommended to avoid smoking cigarettes and/or marijuana for at least 2 days prior to the surgery and 1 week after.

5. Keep in mind that it is best to allow for some flexibility around your appointment time on the day of your surgery. We try our best to stay on schedule to minimize your waiting time but various circumstances may lengthen the time allocated for a procedure.

6. If you are considering IV moderate sedation (Twilight Sleep Sedation), you must have a consultation only appointment first before scheduling the surgery. Consultation appointment is not required for nitrous oxide sedation.

The Dental Extraction Clinic

# Patient Registration

**Name**_____
**Last** **First** **Middle**

**Date of Birth (mm/dd/yyyy)** _____ **Age:**_____

**Social Security #**_____ **Height**_____ **Weight**_____

**Gender (circle one):** MALE FEMALE UNKNOWN
**Pronouns (circle one):** He/Him She/Her They/Them

**If you are completing this form for another person, what is your relationship to that person?**_____

**Address:**_____
**City** **State** **Zip**

**Best Phone Number:** _____
By providing a mobile number, I agree that The Dental Extraction Clinic may send me automated appointment reminders

**Email:**_____

**Guardian (if applicable)**_____ **Phone**_____

**Emergency Contact:**_____**Phone**_____

**How did you hear about us?**_____

**Best Pharmacy for Prescriptions (complete address)**

_____

_____

*****PLEASE BRING YOUR IDENTIFICATION CARD AND, IF APPLICABLE, YOUR MEDI-CAL DENTAL CARD TO YOUR APPOINTMENT****

The Dental Extraction Clinic

# Medical History

**Name**_____**Date of Birth (mm/dd/yyyy)**_____

**What is your reason for today's appointment?**_____

_____

**Are you under the care of a physician? (circle one)** YES NO
**If so, for what condition?** _____

**Please list any allergies or medications that have given you a bad reaction:**

_____

_____

**Please list any medications and/or supplements that you are taking including dosage (bring a list to your appointment if there is inadequate space here):**

_____

_____

_____

**Do you use tobacco and/or THC? If so, what kind and how much?** YES NO

_____

**Have you ever taken an anti-resorptive medication (Fosamax/Alendronate, Actonel, Boniva, Reclast, Aredia, Zometa, Xgeva/Densoumab/Prolia) or Antiangiogenic Drugs (Sutent, Nexavar, Avastin)? (Circle One)** YES NO

**Has there been any change in your general health within the past year?** YES NO

**Have you had any serious illness, operation, or been hospitalized in the past 5 years?** YES NO

**PLEASE CHECK ALL THAT APPLY:**

| | | |
|---|---|---|
| ☐ Alcoholism | ☐ Chronic Obstructive Pulmonary Disease | ☐ Liver Issues |
| ☐ Alzheimers/Dementia | ☐ Diabetes | ☐ Low Blood Pressure |
| ☐ Anemia | ☐ Drug Addiction | ☐ Pain in Jaw Joints |
| ☐ Angina Pectoris | ☐ Emphysema | ☐ Parkinson's |
| ☐ Anxiety | ☐ Epilepsy or Seizures | ☐ Psychiatric Treatment |
| ☐ Arthritis | ☐ Fainting or Dizzy Spells | ☐ Rheumatic Fever |
| ☐ Artifical Heart Valve | ☐ Glaucoma | ☐ Sickle Cell Disease |
| ☐ Artificial Joint | ☐ Heart Attack | ☐ Sinus Trouble |
| ☐ Asthma | ☐ Heart Disease | ☐ Sleep Apnea |
| ☐ Bleeding Issues | ☐ Heart Pacemaker | ☐ Stomach Ulcer |
| ☐ Bruise Easily | ☐ Hemophilia | ☐ Stroke |
| ☐ Cancer | ☐ Hepatitis A or B | ☐ Thyroid Disease |
| ☐ Chemotherapy | ☐ High Blood Pressure | ☐ Tuberculosis |
| ☐ Congenital Heart deformity | ☐ HIV/AIDS | ☐ History of Infective Endocarditis |
| ☐ Cortisone Medication | ☐ Kidney Issues | |

**WOMEN ONLY**

**Are you pregnant? (circle one)** YES NO

**Are you taking birth control pills?** YES NO

_____ _____

**Signature of Patient (or Patient's Guardian)** **Signature of Dentist**

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**OUR LEGAL DUTY**

As a recipient of health care services, you have certain rights. We are required by 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 will follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time. 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 make commercially reasonable efforts to 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.

**OUR USE AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you only as necessary for treatment, payment, and our 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.

**Health Care Operations:** We may use and disclose your health information in connection with our health care operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of Health care 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 health care 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 a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally 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 health care or with payment for your health care, but only if you agree in writing 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, concerning 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 (1) 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 health care and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

**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 may be a 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

**Appointment and Treatment Reminders:** We may use or disclose your health information to provide you with appointment or outstanding treatment reminders.

**PATIENT RIGHTS**

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request 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. You may also request access by sending us a letter to the address at the end of this Notice.

**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, health care

operations and certain other activities, for the last 6years. We will provide such a list at no charge upon your request once in any 12 month period. We reserve the right to charge you for requests in excess of one per 12 month period.

**Restrictions:** 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. (Any such 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 upon your request.

**Questions or Complaints:** To learn more about our privacy practices or if you have questions or concerns, please contact us.

**OFFICE NAME: RIVERO DMD INC DBA THE DENTAL EXTRACTION CLINIC**
**OFFICE CONTACT INFORMATION:**
**3560 Fairmount Ave Suite B**
**San Diego, CA 92105**
**619-877-0124**

**Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this Notice, and I have been given the opportunity to ask any and all questions.**

_____ _____
Signature (Patient/Parent/Guardian) Date

_____
(If patient is minor) Name of Signer and Relationship