Comfort dental

WELCOME TO COMFORT DENTAL PATIENT REGISTRATION & HEALTH HISTORY

All Comfort Dental Offices are owned & operated by independent dentist owned franchises of Comfort Dental Group, Inc.
Questions or comments about this office should be addressed to the dentists in this practice.
Comfort Dental Group, Inc. does not own or operate any dental practices.

PATIENT INFORMATION

PLEASE PRINT CLEARLY

LAST NAME: FIRST NAME: INITIAL: CELL PHONE: HOME PHONE:

GENDER:

◯ MALE ◯ FEMALE ◯ OTHER

MAILING ADDRESS: CITY: STATE: ZIP:

DOB: AGE: DL#: SS#: EMAIL:

EMPLOYER: ADDRESS: HOW LONG: WORK PHONE:

DOB: AGE: SCHOOL: CITY: GRADE:

SPOUSE INFORMATION

PLEASE PRINT CLEARLY

LAST NAME: FIRST NAME: INITIAL: CELL PHONE: HOME PHONE:

GENDER:

◯ MALE ◯ FEMALE ◯ OTHER

MAILING ADDRESS: CITY: STATE: ZIP:

DOB: AGE: DL#: SS#: EMAIL:

EMPLOYER: ADDRESS: HOW LONG: WORK PHONE:

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DENTAL/POLICY HOLDER INFORMATION

SUBSCRIBER LAST NAME: FIRST NAME: INITIAL: DOB: SS#:

INSURANCE NAME MEMBER ID: GROUP #:

ADDRESS: CITY: STATE: ZIP:

SUBSCRIBER LAST NAME: FIRST NAME: INITIAL: DOB: SS#:

ADDITIONAL INSURANCE: MEMBER ID: GROUP #:

ADDRESS: CITY: STATE: ZIP:

Any family members current patients? ◯ YES ◯ NO

NAME:_____

EMERGENCY CONTACT INFORMATION

LAST NAME: FIRST NAME: PHONE NUMBER:

ADDRESS: CITY: STATE: ZIP:

RELATIONSHIP TO PATIENT:

MEDICAL/DENTAL HISTORY

ARE YOU EXPERIENCING DENTAL PAIN OR DISCOMFORT?_____ ◯ YES ◯ NO

ARE YOU IN GOOD HEALTH?_____ ◯ YES ◯ NO

HAS THERE BEEN A CHANGE IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?__ ◯ YES ◯ NO

ARE YOU UNDER THE CARE OF A PHYSICIAN?_____ ◯ YES ◯ NO

IF SO, WHAT CONDITION IS BEING TREATED?_____ ◯ YES ◯ NO

PHYSICIAN'S NAME: PHONE NUMBER:

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DO YOU SMOKE OR USE ANY TOBACCO PRODUCTS?_____ ◯YES ◯NO

ARE YOU PREGNANT OR THINK YOU MIGHT BE?_____ ◯YES ◯NO

PLEASE CHECK ALL THAT APPLY:

- ☐ AIDS (AI)
- ☐ ALCOHOLISM (AL)
- ☐ ANEMIA (AN)
- ☐ ANGINA (AG)
- ☐ ARTIFICIAL HEART VALVE (AV)
- ☐ ARTIFICIAL JOINTS (AJ)
- ☐ ARTHRITIS/RHEUMATISM (AR)
- ☐ ASTHMA
- ☐ BIRTH CONTROL (BC)
- ☐ BLOOD PRESSURE - HIGH (BH)
- ☐ BLOOD PRESSURE - LOW (LH)
- ☐ BLOOD THINNERS (BT)
- ☐ BRUISE EASILY (BB)
- ☐ CANCER (CA)
- ☐ CHEMOTHERAPY/RADIATION
- ☐ CONGENITAL HEART DISEASE
- ☐ DEAF
- ☐ DIABETES (DB)
- ☐ DRUG DEPENDENCY (DD)
- ☐ EATING DISORDER (ED)
- ☐ EMPHYSEMA (EM)
- ☐ EPILEPSY (EP)
- ☐ FAINTING/DIZZY SPELLS (FD)
- ☐ FEVER BLISTERS/COLD SORES (FS)
- ☐ GAG EASILY (GE)
- ☐ GLAUCOMA (GL)
- ☐ HEADACHES - FREQUENT (HF)
- ☐ HEART ATTACK (HA)
- ☐ HEART MURMUR (HM)
- ☐ HEMOPHILIA (HP)
- ☐ HEPATITIS (H)
- ☐ HEREDITARY DISEASE/DEFORMITIES
- ☐ HIV POSITIVE (VP)
- ☐ HERPES (HR)
- ☐ HIVES (HI)
- ☐ HYPER ACTIVITY (HY)
- ☐ HYPOGLYCEMIA (HG)
- ☐ JAUNDICE (JC)
- ☐ KIDNEY/LIVER DISEASE (KL)
- ☐ MITRAL VALVE PROLAPSE HV
- ☐ NIGHT SWEATS (NS)
- ☐ OSTEOPOROSIS (OS)
- ☐ PARALYSIS (PL)
- ☐ PROLONGED BLEEDING (PB)
- ☐ PSYCHIATRIC TREATMENT
- ☐ RHEUMATIC FEVER (RF)
- ☐ SICKLE CELL DISEASE (SD)
- ☐ SINUS TROUBLE (ST)
- ☐ STROKE (SK)
- ☐ TUBERCULOSIS (TB)
- ☐ TUMORS (TM)
- ☐ VENEREAL DISEASE (VD)

HAVE YOU HAD ANY OTHER SERIOUS ILLNESSES? ◯YES ◯NO:
EXPLAIN:

DRUGS/MEDICATIONS

ARE YOU ALLERGIC TO OR HAVE HAD A BAD REACTION TO:

- ☐ ASPIRIN (AA)
- ☐ BARBITURATES (AB)
- ☐ CODEINE (AC)
- ☐ ERYTHROMYCIN (AE)
- ☐ IODINE (AD)
- ☐ KEFLEX (AK)
- ☐ LOCAL ANESTHETIC
- ☐ NITROUS OXIDE (NO
- ☐ NARCOTICS (NA)
- ☐ PENICILLIN (AP)
- ☐ SULFA (AS)
- ☐ TETRACYCLINE (AT)
- ☐ LATEX
- ☐ OTHER ALLERGIES (LIST)

_____

_____

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HAVE YOU TAKEN ANY MEDICATION IN THE LAST 6 MONTHS? ◯ **NO** ◯ **YES - PLEASE LIST** _____

_____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING RIGHT NOW: _____

_____

PREFERRED PHARMACY NAME: _____

PHARMACY ADDRESS: _____ **PHONE NUMBER:** _____

REASON: _____

DR. SIGNATURE: _____

CONSENT: As the undersigned, I hereby authorize Doctor to, after thorough explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated (after they are discussed with me) and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due, and payable at time services are rendered.
All proceeds of insurance are assigned to the doctor when applicable, but without the doctor assuming responsibility for the collection of those claims. If the insurance company does not pay my claim within 60 days after it is mailed, it is understood that I pay the balance of my account and that I contact my insurance company regarding settlement. It is agreed that payment will not be delayed or withheld because of pending insurance coverage. If I do not pay the entire balance, or if insurance is unpaid after 60 days, a billing charge will be added to my account. The billing charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.00 for a balance under $100) which is an annual percentage rate of 18%. In case of default of payment, I agree to pay any and all costs in collecting this account, including but not limited to attorney fees and court costs. I understand that, where appropriate, credit reports may be obtained.

PATIENT/PARENT SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____ DATE: _____ WITNESS: _____

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GENERAL CONSENT

I understand that my treatment plan for today includes the following work listed below.

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, bruising, pain, limited mouth opening, itching, accelerated heart rate, vomiting, and/or anaphylactic shock. I also know that paresthesia numbness is a possible risk of injection that can last permanently or for an indefinite period of time.

I understand that during treatment it may be necessary to change or add procedures because of conditions that were not discovered during examination, but were found while working on the teeth. For example, root canal therapy may be discovered to be needed during routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary.

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and have authorized. I understand that no other dentist is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of the treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or consultation costs that may be incurred to satisfy this obligation. I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

PATIENT/PARENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

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AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers, and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide names of family members or friends you would like to authorize us to release & discuss your dental information. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "DO NOT RELEASE INFORMATION" box below. I give the following named person(s) authorization to take messages or speak with the office on my behalf regarding (please check all items authorized):

NAME: _____ RELATIONSHIP: _____

PHONE #:_____ ☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance

Other (explain):_____

NAME: _____ RELATIONSHIP: _____

PHONE #:_____ ☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance

Other (explain):_____

NAME: _____ RELATIONSHIP: _____

PHONE #:_____ ☐ Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance

Other (explain):_____

☐ DO NOT RELEASE INFORMATION

I understand that my express consent is required for any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above

PATIENT NAME: _____ DOB: _____

PATIENT OR REPRESENTATIVE SIGNATURE:_____ DATE:_____

Comfort dental

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____, have a copy of this office's Notice of Privacy Practices
(please print name)

_____
(printed name of responsible party (If patient is a minor)

SIGNATURE:_____ DATE:_____

FOR 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 (Please Specify) _____

_____

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Comfort dental

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 your 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 April 14, 2003, 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 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 a payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our 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 your 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 you with your healthcare or payment for your healthcare, but only if you agree that we may do so.

Person 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 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 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.

Notice of Privacy Practices

Effective Date: 2/16/2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. If you are a minor, your parent or legal guardian must read this notice and handle your privacy rights for you. PLEASE REVIEW THIS CAREFULLY.

Our Responsibilities. Your Rights.

We are committed to safeguarding your PHI and ensuring compliance with applicable federal and state privacy laws. When using or disclosing your PHI, we will limit the information to the minimum necessary to accomplish the intended purpose, except in cases where this standard does not apply, such as disclosures to you or with your written authorization. We are required by law to adhere to the terms of this notice as currently in effect. We will notify you in writing if we make changes to this notice. You may request a copy of this notice at any time by contacting us at the contact information provided on the last page of this notice.

You have the following rights regarding your PHI:

- **Right to Access**. You have the right to inspect and obtain a copy of your PHI in our designated record set, such as medical or billing records, for as long as we maintain the information. We may charge a reasonable, cost-based fee for copies. We will respond to your request within 30 days unless we require an extension.
- **Right to Amend**. If you believe your PHI is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances, such as if we did not create the information. We will respond to your request within 60 days.
- **Right to Accounting of Disclosures**. You have the right to request a list of certain disclosures of your PHI made by us during the past six (6) years (or a shorter period, if applicable). The list will not include disclosures for treatment, payment, health care operations, or disclosures you authorized. We will respond to your request within 60 days unless we require an extension. We will provide one (1) accounting per year at no charge; additional requests may incur a reasonable, cost-based fee.
- **Right to Request Restrictions**. You have the right to request restrictions on how we use or disclose your PHI for treatment, payment, or health care operations, or to certain individuals involved in your care. We are not required to agree to your request, except for disclosures to your health plan for services you paid for out of pocket in full.
- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about your PHI in a specific way or at a specific location, such as by email or at an alternate address. We will accommodate reasonable requests.
- **Right to Paper Copy of This Notice**. You have the right to receive a paper copy of this notice at any time, even if you have agreed to receive it electronically.

How We May Use and Disclose Your Protected Health Information.

The following sections describe the ways we may use and disclose your PHI, including examples to help you understand these uses and disclosures. Not every possible use or disclosure is listed, but all uses and disclosures will comply with applicable laws.

1. Uses and Disclosures for Treatment, Payment, and Health Care Operations. We may use and disclose your PHI for the following purposes without your authorization, unless otherwise restricted by law:

- **Treatment**. We may use your PHI to provide, coordinate, or manage your health care and related services. We may also disclose your PHI to other health care providers involved in your care.

Example: We may share your medical records with a specialist to coordinate your treatment plan or provide your PHI to a hospital where you are receiving care.

- **Payment**. We may use and disclose your PHI to bill and collect payment for the services we provide, including submitting claims to your health insurance plan.

  Example: We may send your PHI to your insurance company to verify coverage or obtain payment for a procedure.

- **Health Care Operations**. We may use and disclose your PHI for activities necessary to operate our practice, such as quality improvement, staff training, or compliance audits.

  Example: We may review your PHI to evaluate the quality of care provided or train our staff on privacy practices.

You have the right to request restrictions on how your PHI is used or disclosed for treatment, payment, or health care operations. While we are not required to agree to your request, we will consider it carefully and notify you of our decision.

2. Uses and Disclosures Requiring Your Authorization. For uses and disclosures of your PHI not described in this notice, we will obtain your written authorization, except as permitted or required by law. Examples include:

- **Marketing**. We will not use your PHI for marketing purposes without your authorization.
- **Sale of PHI**. We will not sell your PHI without your authorization.
- **Psychotherapy Notes**. We will not use or disclose psychotherapy notes without your authorization, except for limited purposes, such as treatment or legal compliance.

You may revoke an authorization in writing at any time, and we will stop using or disclosing your PHI for the purposes covered by the authorization, except for actions already taken.

In addition to the uses and disclosures described above, we will abide by any more stringent requirements imposed by applicable state laws regarding the sale or other disclosures of your PHI. If state law prohibits or further restricts a disclosure that would otherwise be permitted under federal law, we will not make that disclosure.

3. Uses and Disclosures Permitted Without Your Authorization. We may use or disclose your PHI without your authorization in the following situations, subject to applicable legal requirements:

- **Required by Law**. We may disclose your PHI when required by federal, state, or local law, provided the disclosure complies with all applicable conditions.
- **Public Health Activities**. We may disclose your PHI to public health authorities for activities such as preventing or controlling disease, reporting births and deaths, or notifying individuals of product recalls.
- **Health Oversight Activities**. We may disclose your PHI to government agencies for oversight activities, such as audits or investigations of health care providers.
- **Judicial and Administrative Proceedings**. We may disclose your PHI in response to a court order, subpoena, or other lawful process, subject to specific protections described below.
- **Law Enforcement Purposes**. We may disclose your PHI to law enforcement officials for purposes such as identifying a suspect or reporting a crime on our premises, subject to specific protections described below.

- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose your PHI to coroners or medical examiners to identify a deceased person or determine the cause of death, or to funeral directors to carry out their duties.
- **Organ and Tissue Donation**. We may disclose your PHI to organizations that handle organ, eye, or tissue donation or transplantation.
- **Research**. We may use or disclose your PHI for research purposes under strict conditions, such as with approval from an Institutional Review Board.
- **To Prevent a Serious Threat to Health or Safety**. We may disclose your PHI to prevent a serious threat to your health or safety or that of others.
- **Specialized Government Functions**. We may disclose your PHI for military activities, national security, or to correctional institutions if you are an inmate.
- **Workers' Compensation**. We may disclose your PHI to comply with workers' compensation laws or similar programs.

4. Reproductive Health Care Information. Reproductive health care includes care affecting the reproductive system, such as contraception, fertility treatments, abortion, miscarriage care, and over-the-counter medications or devices. On June 18, 2025, a federal court in Texas (*Purl v. HHS*) struck down certain 2024 HIPAA Privacy Rule provisions that provided additional protections for reproductive health care information, ruling that the U.S. Department of Health and Human Services exceeded its authority. As a result, we handle PHI related to reproductive health care under standard HIPAA rules and applicable state laws. When we receive PHI about reproductive health care provided by another health care provider, we presume such care was lawful unless we have clear evidence to the contrary.

5. Special Protections for Substance Use Disorder Treatment Records. If we maintain records of your SUD treatment from a federally assisted program, these records are protected by federal law under 42 CFR Part 2, "Confidentiality of Substance Use Disorder Patient Records." These protections apply to information that could identify you as having or having had a substance use disorder. The following rules apply:

- **Limitations on Use and Disclosure**. We will not use or disclose your SUD treatment records, or testimony about them, in civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order accompanied by a subpoena or other legal requirement.

  > *Example*: We will not disclose your SUD treatment records to a court for use in a criminal proceeding against you unless you provide written consent or a court issues an order with a valid subpoena.

- **Redisclosure Warning**. If we disclose your SUD treatment records to an entity not covered by HIPAA, such as a social service agency, that information may be redisclosed by the recipient and may no longer be protected by federal privacy laws.

  > *Example*: If we share your SUD treatment records with a non-HIPAA-covered entity, that agency may share the information with others, and it will no longer be protected by HIPAA or federal law under 42 CFR Part 2.

- **Your Rights**. You have the right to request restrictions on how your SUD treatment records are used or disclosed for treatment, payment, or health care operations. You may also file a complaint if you believe your privacy rights have been violated, and we will not retaliate against you for doing so. Complaints about SUD records can be filed with the U.S. Department of Health and Human Services.
- **Fundraising Communications**. If we plan to contact you for fundraising purposes and maintain SUD treatment records, we will notify you of our intent and provide you with an opportunity to opt out of receiving such communications.

6. **Disclosures to Business Associates**. We may share your PHI with our business associates, such as billing companies or electronic health record vendors, who perform services on our behalf. We require these business associates to sign agreements to protect your PHI in accordance with HIPAA and 42 CFR Part 2 where applicable.

7. **Disclosures to Family, Friends, or Others Involved in Your Care**. We may disclose your PHI to a family member, friend, or other person you designate as involved in your care or payment for your care, unless you object. If you are not present or are incapacitated, we may disclose your PHI if we believe it is in your best interest.

Notice of PHI Breach.

If a breach of your PHI occurs, we will notify you as required by federal and state law.

Complaints.

If you believe your privacy rights have been violated, you may file a complaint us or with the Office for Civil Rights at the U.S. Department of Health and Human Services.

To file a complaint with us, please write to us using the contact information provided below. All complaints must be submitted to us in writing. **We will not retaliate against you for filing a complaint**.

For complaints related to SUD treatment records, you may also contact the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: (800) 368-1019

Changes to This Notice.

We reserve the right to change this notice at any time from time to time and make the revised notice effective for PHI we already have about you as well as any PHI we receive in the future. We will post a copy of the current notice in our office and/or on our website, with the effective date stated. You may request a paper copy of the current notice at any time.

Contact Information.

For questions about this notice, to request a paper copy, or to file a complaint, please contact your local office. Office contact information can be found by searching our office directory at https://comfortdental.com/find-a-dentist-directory/.