ROSE DENTAL GROUP & ORTHODONTICS
2731 S Rose Ave #101, Oxnard, CA 93033
OxnardRoseDental.com
(805) 483-3658

Date:_____

Patient's name _____ Title ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other_____
Nickname _____ Sex M☐ F☐ Birthdate _____ Age _____ Social security #_____

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Spouse's name (if applicable) _____

Home address _____ City, state, zip code _____

Work phone _____ Cell phone _____ Email _____

Preferred method of contact _____

Employer _____ Occupation _____ # years employed _____

General dentist _____ Date last seen_____ Reason _____

Other dentist/specialists currently seeing _____ Reason _____

Reason(s) for seeking an evaluation with our office _____

Whom may we thank for referring you? _____

Names and ages of children in the family _____

Responsible party ☐ Check if same as above OR complete below section

Name _____ Relationship to patient _____

Birthdate _____ Social security #_____

Home address _____ City, state, zip code _____

Work phone _____ Cell phone _____ Email _____

Employer _____ Occupation _____ No. Years Employed _____

Emergency contact name _____ Relationship to patient _____

Work phone _____ Cell phone _____

Primary Orthodontic Insurance

Policy owner's employer _____

Insurance company name _____

Group _____ ID # _____

Address _____

Phone # to verify benefits _____

Policy owner's name _____

Relationship to Patient _____

Birthdate_____Social security # _____

Secondary Orthodontic Insurance

Policy owner's employer _____

Insurance company name _____

Group _____ ID # _____

Address _____

Phone # to verify benefits _____

Policy owner's name _____

Relationship to Patient _____

Birthdate_____Social security # _____

Our office will make every attempt to contact your insurance company(s) based on the information that you provide us. We will verify whether coverage exists for treatment and coverage limits. We file and accept assignment of orthodontic insurance benefits. However, the responsible party is responsible for all amounts unpaid by insurance for any reason. *Typically orthodontic insurance is paid over the course of the treatment and not in one lump sum, regardless of how you pay our office.*

I authorize assignment of insurance benefits to Rose Dental if I have a balance on my account with the office.

Signature of responsible party _____ Date _____

Medical History

Name of medical physician _____ Phone number _____

Is the patient currently under the care of a physician? ☐ Yes ☐ No If yes, please describe _____

Does the patient have a history of major illness? ☐ Yes ☐ No If yes, please describe _____

Check any of the following for which the patient has been treated for or has a history of:

☐ ADD/ADHD	☐ Circulatory problems	☐ Heart murmur	☐ Pacemaker
☐ AIDS or HIV	☐ Cleft lip and/or palate	☐ Heart problems	☐ Psychiatric care
☐ Anemia	☐ Craniofacial syndrome	☐ Hemophilia	☐ Respiratory disease
☐ Arthritis, joint problems	☐ Diabetes	☐ Hepatitis	☐ Shortness of breath
☐ Artificial heart values	☐ Depression	☐ High blood pressure	☐ Sleep apnea
☐ Artificial joints	☐ Eating disorder	☐ Injury to face, head, neck	☐ Skin disorder
☐ Asthma	☐ Endocrine problems	☐ Kidney disease	☐ Speech problems
☐ Back problems	☐ Epilepsy	☐ Liver disease	☐ Stomach ulcer or acid reflux
☐ Blood transfusion	☐ Excessive bleeding/bruising	☐ Learning disability	☐ Stroke
☐ Bone fractures	☐ Fainting or dizziness	☐ Major surgery	☐ Tobacco habit
☐ Cancer or tumor	☐ Frequent earaches	☐ Mitral value prolapse	☐ Tonsil or adenoid condition
☐ Chemical dependency	☐ Frequent headaches	☐ Nervous problems	☐ Tuberculosis
☐ Chemotherapy/ radiation	☐ Glaucoma	☐ Osteoporosis	☐ Venereal disease

Any other significant medical problems/events we should be aware of? _____

Have tonsils & adenoids been removed? ☐ Yes ☐ No If yes, at what age? _____

List any medication that you take:

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

List any allergies or drug sensitivities _____

Dental History

Have you had any injuries to the face, mouth, or teeth? ☐ Yes ☐ No

Have you ever sucked a thumb or fingers? ☐ Yes ☐ No If yes, until what age? _____

Are you a mouth breather? ☐ Yes ☐ No If yes, when? ☐ Daytime ☐ While sleeping ☐ Both

Does anyone in the family have an underbite? ☐ Yes ☐ No

Are you aware of any missing or extra permanent teeth? ☐ Yes ☐ No

How many times a day do you brush your teeth? _____

Have you consulted another orthodontist? ☐ Yes ☐ No

Have you ever received orthodontic treatment? ☐ Yes ☐ No If yes, please explain: _____

Has anyone in the family had braces or received any orthodontic treatment? ☐ Yes ☐ No

In our office? ☐ Yes ☐ No Names: _____

Please classify the patient's desire for treatment: ☐ Excited ☐ Indifferent ☐ Objects

Would you consider surgical treatment if necessary? ☐ Yes ☐ No

What kind of treatment interests you?

☐ Traditional metal braces ☐ Cosmetic braces ☐ Removable aligners ☐ I need more info to make a decision

Please list any other significant dental events that we should be aware of _____

Do you have any special concerns about treatment? _____

To the best of my knowledge, the above information is complete and correct. I will not hold my orthodontist or their staff accountable for any errors or omissions that I have made in completion of this form. I will notify my orthodontist with any changes in my medical or dental history.

Signature _____ Date _____

ROSE DENTAL GROUP & ORTHODONTICS
2731 S Rose Ave #101, Oxnard, CA 93033
OxnardRoseDental.com
(805) 483-3658

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, Date of Birth _____,
(Patient Name)

request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, Diagnosis (es), test results, date of services.

- Sensitive Protected Health Information
- You may disclose information to my family members and/or non-family members

Please list the name, phone number, and relationship

NAME	PHONE NUMBER	RELATIONSHIP

- You may leave Protected Health Information on my answering machine/voicemail:
  Phone Number _____
- You may leave me a text message: Text Phone Number _____
- You may email me (unencrypted) for dental appointments:
  Email Address _____
- You may fax me for dental information: Fax Number _____
- Other _____

*I would like to receive a copy of this office's Notice of Privacy Practices. ☐ Yes ☐ No

Print Name: _____

Signature: _____ Date: _____
(Patient's Signature (or Guardian, if Minor)

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 acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

_____	_____
Staff Initials	Date

ROSE DENTAL GROUP & ORTHODONTICS
2731 S Rose Ave #101, Oxnard, CA 93033
OxnardRoseDental.com
(805) 483-3658

NOTICE OF PRIVACY PRACTICES

Effective Date 2/14/2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page and will remain in effect unless we replace it. We reserve the right at any time 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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change in practices.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you, the revised notice. Any revised notice will be effective for all health information we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website. You may request a copy of the current notice at any time. We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction and misuse.

Treatment: We may disclose your medical information, without your prior approval, to another dentist or healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan or from you. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Healthcare Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management and general administration including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has had a relationship with you and the medical information is for that provider's or health plan's care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose that information. You may take back or "revoke" your written authorization at any time, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of these communications at any time.

Business Associates: We may disclose your medical information, without your prior notice, to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. Medical information will only be used or disclosed if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Your Family, Friends, and Others involved in your care or payment for care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose on the medical information that is relevant to the person's involvement.

We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders via US Mail, email, telephone and texting. By providing your email address to us, you agree that you may receive reminders and breach notifications via email as a possible alternative to US Mail. It is the policy of our office to leave a message on any voicemail or answering machine that may be attached to a number that you provide (home, cell or work). You may opt out of this service.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and when authorized by law for the following kinds of public health and public benefit activities;

- for public health, including to report disease and vital statistics, child abuse, adult abuse, neglect or domestic violence;
- to avert a serious an imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to
- correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

Special protections for SUD records: Substance Use Disorder (SUD) Treatment records have enhanced protections. They cannot be used in legal proceedings without your consent or court order.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Abuse or Neglect: We may disclose your medical records to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your medical information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: Under certain circumstances, we may disclose medical records to military authorities as required for lawful intelligence, counterintelligence, and other national security activities.

Under certain circumstances, we may disclose medical information to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your contact information to provide legally required notices of unauthorized acquisition, access or disclosure of your health information.

Additional Restrictions on use and disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly Confidential Information" may include confidential information under Federal laws governing reproductive

rights, alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1) HIV/AIDS;
2) Mental Health;
3) Genetic Tests (in accordance with GINA 2009);
4) Alcohol and drug abuse;
5) Sexually transmitted diseases and reproductive health information; and
6) Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS:

1) You have a right to see and get a copy of your health records.
2) You have a right to amend your health information.
3) You have a right to ask to get an Accounting of Disclosures of when and why your health information was shared for certain purposes.
4) You are entitled to receive a Notice of Privacy Practices that tells you how your health information may be used and shared.
5) You may decide if you want to give your Authorization before your health information may be used or shared for certain purposes, such as marketing. It is the policy of our office NOT to sell or disclose your information to any outside firms or business partners. Your information may be used, only within our office, for the purposes of presenting to you certain products or services which our dentist(s) or staff feel may present a benefit for you, your oral health or happiness with your smile. You have the right to opt out of this level or service.
6) You have the right to receive your information in a confidential manner and restrict certain communication methods.
7) You have a right to restrict who receives your information, unless they are a legal guardian.
8) You have a right to request amendment to be made to your health records by submitting the request in writing to our privacy officer. Your request does not guarantee the amendment, but does guarantee that it will be reviewed and considered.
9) If you believe your rights are being denied or your health information is not being protected, you can:
   a. File a complaint with your provider or health insurer
   b. File a complaint with the U.S. Government
10) Right to opt out of fundraising activities. If you would like to opt out of any fundraising programs that our office may participate in, such as cancer walks, or other fundraising programs.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact our Privacy Officer to register either a verbal or written complaint.

You may also submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC, 20201. You may contact the Office for Civil Rights' hotline at 1-800-368-1019. We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Contact Officer: Omar Rojas
Address: Rose Dental - 2731 S Rose Ave #101, Oxnard, CA 93033
Telephone: (805) 483-3658

Email: info@OxnardRoseDental.com