PATIENT INFORMATION:

NAME: _____
FIRST *MI* *LAST*

ADDRESS _____ *APT. NO.* _____

CITY _____ *STATE* _____ *ZIP* _____

BIRTHDATE _____ *SSN* _____
MONTH *DAY* *YEAR*

HOME PHONE ( ) _____

WORK PHONE ( ) _____

CELLPHONE ( ) _____

_____
DRIVERS LICENSE NUMBER *STATE*

EMPLOYER/OCCUPATION: _____

IN CASE OF EMERGENCY, CONTACT : _____ RELATIONSHIP _____ PHONE ( ) _____

IF THE PERSON RESPONSIBLE FOR THE ACCOUNT IS DIFFERENT THAN THE PATIENT, PLEASE FILL IN THIS SECTION:

NAME: _____ *AGE* _____ *SEX* _____
FIRST *MI* *LAST*

ADDRESS _____ *APT. NO.* _____

CITY _____ *STATE* _____ *ZIP* _____

BIRTHDATE _____ *SSN* _____
MONTH *DAY* *YEAR*

HOME PHONE ( ) _____

WORK PHONE ( ) _____

CELLPHONE ( ) _____

DO YOU HAVE ANY DENTAL INSURANCE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE NAME AND ID NUMBER: _____

PATIENT TREATMENT CONSENT :

- **I authorized the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.**
- **I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records/ x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested.**
- **I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 5% per month.**

Patient / Parent or Guardian Signature : _____ Date: _____

DENTAL HISTORY:

WHAT IS THE REASON FOR THIS APPOINTMENT? _____

ARE THERE ANY SPECIFIC DENTAL PROBLEMS WE SHOULD BE AWARE OF? _____

_____

DO YOU THINK YOU HAVE ANY TOOTH DECAY OR CAVITIES ? ☐ **YES** ☐ **NO**

DOES YOUR GUM BLEED WHEN BRUSHING OR FLOSSING? ☐ **YES** ☐ **NO**

DO YOU SUFFER FROM CHRONIC BAD BREATH OR BAD TASTE? ☐ **YES** ☐ **NO**

DO YOU HAVE ANY JAW JOINT CRACKING OR PAIN? ☐ **YES** ☐ **NO**

WHEN WAS THE LAST TIME YOU HAD A DENTIST VISIT? _____ **NAME OF PREVOIUS DENTIST?** _____

WHEN WAS THE LAST TIME YOU HAD A DENTAL EXAM AND CLEANING? _____

HOW WOULD YOU DESCRIBE YOUR DENTAL HEALTH? ☐ **EXCELLENT** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

I AM ☐ **VERY SATISFIED** ☐ **SATISFIED** ☐ **DISSATISFIED** **WITH THE APPEARANCE OF MY TEETH.**

I THINK MY PRESENT STATE OF DENTAL HEALTH IS ☐ **EXCELLENT** ☐ **GOOD** ☐ **FAIR** ☐ **POOR**

I WOULD SAY THAT MY MAIN CONCERNS WITH MY TEETH ARE: _____

I AM INTERESTED IN A SMILE EVALUATION AND PERSONALIZED TREATMENT PLAN TO ENHANCE MY SMILE. ☐ **YES** ☐ **NO**

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Patient / Parent or Guardian Signature : _____ **Date:** _____

MEDICAL HISTORY

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide is with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR :

	YES	NO		YES	NO		YES	NO
ANY HEART PROBLEMS	☐	☐	DO YOU SMOKE	☐	☐	ALLERGIC REACTION TO:	☐	☐
HEART MURMUR	☐	☐	LUNG/BREATHING PROBLEMS	☐	☐	PENICILLIN	☐	☐
MITRAL VALVE PROLAPSE	☐	☐	ASTHMA	☐	☐	ERYTHROMYCIN	☐	☐
HEART VALVE DEFECT	☐	☐	BRONCHITIS	☐	☐	SULFA	☐	☐
HEART VALVE REPLACEMENT	☐	☐	EMPHYSEMA	☐	☐	CODEINE	☐	☐
RHEUMATIC FEVER	☐	☐	TUBERCULOSIS	☐	☐	ASPIRIN	☐	☐
ARTIFICIAL JOINT (HP/ KNEE)	☐	☐	SINUS TROUBLE	☐	☐	LATEX	☐	☐
ANGINA	☐	☐	DIFFICULTY IN HEALING	☐	☐	LOCAL ANESTHETIC	☐	☐
STROKE	☐	☐	DIABETES	☐	☐	OTHER MEDICATIONS OR	☐	☐
HEART ATTACK	☐	☐	THYROID PROBLEMS	☐	☐	SUBSTANCES? Please list:	☐	☐
BYPASS	☐	☐	ADRENAL/PITUITARY PROBLEMS	☐	☐	_____		
PACEMAKER	☐	☐	LIVER PROBLEM/DYSFUNCTION	☐	☐	_____		
HIGH BLOOD PRESSURE	☐	☐	HEPATITIS / JAUNDICE	☐	☐	CANCER / TUMOR	☐	☐
LOW BLOOD PRESSURE	☐	☐	KIDNEY PROBLEMS/DYSFUNCTION	☐	☐	OTHER GROWTHS	☐	☐
ANY BLEEDING DISORDERS	☐	☐	STOMACH TROUBLE / ULCERS	☐	☐	CHEMOTERAPHY/RADIATION THERAPHY	☐	☐
ANEMIA	☐	☐	NERVOUS OR MENTAL DISORDER	☐	☐	SEXUALLY TRANSMITTED DISEASE	☐	☐
HEMOPHILIA	☐	☐	EPILEPSY OR SEIZURES	☐	☐	OTHER INFECTIOUS DISEASES	☐	☐
SICKLE CELL TRAIT	☐	☐	ALCOHOLISM	☐	☐	HIV / AIDS	☐	☐
BLOOD TRANSFUSIONS	☐	☐	DRUG ABUSE	☐	☐	ARE YOU PREGNANT?	☐	☐

PLEASE DESCRIBE ANY CURRENT HEALTH PROBLEMS NOT LISTED ABOVE _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? ☐ **YES** ☐ **NO** **WHY?** _____

PHYSICIAN'S NAME AND PHONE: _____

ARE YOU PRESENTLY TAKING ANY MEDICATIONS? ☐ **YES** ☐ **NO**

LIST _____ **FOR** _____ **LIST** _____ **FOR** _____

LIST _____ **FOR** _____ **LIST** _____ **FOR** _____

LIST _____ **FOR** _____ **LIST** _____ **FOR** _____

LIST _____ **FOR** _____ **LIST** _____ **FOR** _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WILL INFORM THE DENTIST OF ANY CHANGES IN MY HEALTH STATUS OR MY MEDICATIONS.

_____	_____	_____ _____
DATE	**PATIENT / GUARDIAN SIGNATURE**	**DOCTOR / HYGIENIST SINATURE**

BROKEN APPOINTMENT POLICY

The time the doctor sets aside for a patient is valuable. The dental appointment reserved for your care places responsibility on the doctor and the patient. In order to provide quality dental care at an affordable cost these appointments must be kept.

Our office has a broken appointment charge for every 15 minutes of appointment time a patient has failed without giving a 24 hour prior notice. There is no insurance coverage for this charge.

Patient's signature _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this *Acknowledgement*

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

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*
- ☐ *Communications barriers prohibited obtaining the acknowledgement*
- ☐ *An emergency situation prevented us from obtaining acknowledgement*
- ☐ *Other (Please Specify)*

Drs. Vandermer, Lee, Sedighian

NOTICE OF PRIVACY PRACTICE

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 FEBRUARY 1, 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 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 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.

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 voice mail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. 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.___ for each page, $___ 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 Service.