PATIENT INFORMATION

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐

Name____
(Last) (First) (Middle)

Home Address____
(Street) (City) (Zip)

Home Phone________________Work Phone________________Cellphone________________________

Email Address ________________________ Driver's License ____________________________

Age________________ Birth Date____________________Marital Status: S M W D Sep

Employer________________________Business Address__________________________________

Position____________________How Long______________Social Security #__________________________

Spouse__________________________Employer_______________________Position________________________

Business Address____________________________Phone____

Primary Dental Insurance_________________Subscriber name/SSN______________________________________

Secondary Dental Insurance_________________Subscriber name/SSN____________________________________

Person to notify in Emergency_____________________Relationship______________________________________

Address____Phone______________________________________

Party responsible for this account____

Name of Dentist_________________________How Long?___________City________________________________

Phone #_______________________________

Name of Physician_______________________ How Long?____________City_______________________________

Phone #_______________________________

Who May We Thank For This Referral____

All accounts are due and payable at time of service rendered. If it is necessary to extend payment for more than 30 days, specific arrangements must be made in advance.

So that we may assure you and other patients of uninterrupted treatment it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees.

Once an appointment is made, please remember this time is reserved for you. At least <u>48 business hours</u> notice must be given for cancellation, otherwise cancellation charges will be made.

I HAVE READ AND UNDERSTAND THE ABOVE

Date________________Signed____

MEDICAL/DENTAL HISTORY

1. Are you having pain or discomfort at this time? YES NO
   Please explain: ____
2. Do you feel very nervous about having dental treatment? YES NO
3. Have you ever had a bad experience in a dental office? YES NO
4. Have you been a patient in the hospital during the past two years? YES NO
5. Have you been under the care of a medical doctor during the past two years? YES NO
6. Have you taken any medicine or drugs during the past two years? YES NO
   Please list all current medications: ______________________________________
7. Are you allergic to, sensitive to or made sick by *penicillin*, other medications or *latex*? YES NO
   Please list all known allergies: ____
8. Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? YES NO
9. Do you take, or have you ever taken any of the groups of drugs called bisphosphonates i.e Fosamax ? YES NO
10. Do you or have you ever smoked? How many packs per day? _____ When did you quit? ______ YES NO
11. Have you ever had any excessive bleeding requiring special treatment? YES NO
12. Do you wear contact lenses? YES NO
13. Do you have bad breath? YES NO
14. Do your gums bleed when you brush your teeth? YES NO
15. Do you grind or clench your teeth or have been diagnosed with TMJ, TMD, or bruxism? YES NO
16. Are your teeth sensitive? If yes, to: hot_____ cold_____ sweets_____when biting _____ YES NO

Please indicate YES or NO by circling the following:

AIDS/HIV+	YES NO	Drug Addiction	YES NO	Kidney Trouble	YES NO
Allergies	YES NO	Emphysema	YES NO	Liver Disease	YES NO
Anemia	YES NO	Epilepsy or Seizures	YES NO	Mitral Valve Prolapse	YES NO
Angina Pectoris	YES NO	Fainting or dizziness	YES NO	Nervousness	YES NO
Arthritis/Rheumatism	YES NO	Genital Herpes	YES NO	Psychiatric Care	YES NO
Artificial Heart Valve	YES NO	Glaucoma	YES NO	Radiation/Chemotherapy	YES NO
Artificial joint	YES NO	Hay Fever	YES NO	Rheumatic Fever	YES NO
Asthma	YES NO	Heart disease or attack	YES NO	Scarlet Fever	YES NO
Blood Transfusion	YES NO	Heart Failure	YES NO	Sickle Cell Disease	YES NO
Bruise Easily	YES NO	Heart Murmur	YES NO	Sinus Trouble	YES NO
Cancer	YES NO	Heart Pacemaker	YES NO	Skin Disorders	YES NO
Cold Sores	YES NO	Heart Surgery	YES NO	Stroke	YES NO
Congenital heart lesions	YES NO	Hemophilia	YES NO	Tuberculosis	YES NO
Cortisone medicine	YES NO	Hepatitis A__B__C__	YES NO	Thyroid Disease	YES NO
Cough	YES NO	High Blood Pressure	YES NO	Ulcers	YES NO
Diabetes	YES NO	Jaw Pain	YES NO	Venereal Disease	YES NO

17. When you walk upstairs or take a walk do you ever have to stop because of pain in your chest or shortness of breath or because you are very tired? YES NO
18. Do your ankles swell during the day? YES NO
19. Have you had retinal surgery within the last year? YES NO
20. Have you lost or gained more than 10 pounds in the past year? YES NO
21. Do you ever wake up from sleep short of breath? YES NO
22. Are you on a special diet? YES NO
23. Do you have any disease, condition, or problem not listed above? YES NO
24. WOMEN: Are you pregnant now or do you anticipate becoming pregnant? YES NO
    Are you practicing birth control? YES NO
    Are you nursing? YES NO

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

________________________ ____

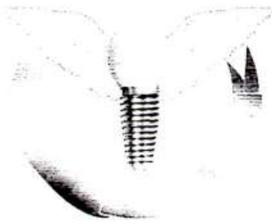
Date Signature of patient, parent or guardian

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition	Signature
___________	______________________________________	_______________
___________	______________________________________	_______________
___________	______________________________________	_______________
___________	______________________________________	_______________

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition	Signature



ARASH AFTABI, D.M.D.

Advanced Micro-Surgical Periodontics & Implants

HEALTH COORDINATION/FINANCIAL ARRANGEMENTS/CONSENT FOR TREATMENT

We would like to thank you for choosing us as your health care provider. We are committed to providing you with the finest care and service possible. We believe the best relationships are based on mutual understanding. We have established the following policies so we may consistently provide all of our patients with the finest quality care. Please take a few moments to thoroughly read this agreement and to sign your name and date each space we have provided below.

PATIENT RECORDS AND FORMS

It is extremely important for all patients to complete and sign the health related information forms as accurately as possible, especially any medication currently being taken. This assists us in becoming familiar with your medical history and allows us to provide health care designed to meet your specific needs.

APPOINTMENT CANCELLATION/SERVICE CHARGES

Due to the nature of our services, we do not schedule other appointments at the same time. If you do not keep the appointment reserved for you the time is not used. If you are not able to notify us of your need to reschedule your appointment within a minimum of 48 hours notice, your account will incur a **$60** service charge for regular appointments, **$150** for surgical appointments. A $25 handling fee will be charged for any returned check. **A 1.67% service charge will be assessed on any account balance over 90 days.**

******I have read and understand the above. I hereby consent to examination by Dr. Aftabi******

Signature: ______________________________ Date: ______________________________

PAYMENT FOR SERVICES/INSURANCE AUTHORIZATION

The fees in our office are based on the time and expense involved in providing the services and the care, skill and judgement necessary to provide service. Payment/insurance co-payments are due in full for each appointment as service is rendered. For your convenience, we offer the following payment options: cash, check, Visa, MasterCard and CareCredit. Our staff will discuss your proposed treatment and assist in determining what portion of your treatment may be covered under your dental insurance plan. If your plan requires original signature and/or insurance forms, it is your responsibility to provide the necessary forms. Your insurance policy is an agreement between you and the insurance company. Please understand we do not allow the limitations of any insurance policy to dictate our treatment plans and you will be responsible for any portion of the fee your insurance does not cover. The prompt billing of claims once service is rendered is a courtesy we extend to our patients to ensure the maximum benefits allowed are received in a timely manner. Please be aware this does not absolve you as the responsible party. If payment is not received from your insurance company within 60 days of submission, the amount due is then your responsibility.

******I authorize my insurance company to pay Dr. Aftabi all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Aftabi to release any/all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.******

Signature: ______________________________ Date: ______________________________

Periodontics • Implants

13001 Seal Beach Blvd. #310
Seal Beach, CA 90740
(562) 431-4200 • Fax: (562) 431-6134

13420 Newport Ave., Suite H
Tustin, CA 92780
(714) 840-1600

info@draftabi.com • www.draftabi.com

Notice of Privacy Practices

This notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that are outlined in this notice while it is in effect. This notice takes effect immediately 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 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. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and health care operations.
For example:

Treatment
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment
We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Health Care Operations
We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, 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 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 is 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.

Notice of Privacy Practices (continued)

To Your Family and Friends
We must disclose your health information to you, as described in the Patient Rights section of this notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other person identified by you.

Unsecured Email
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 your 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 health care. 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 may contact you about products or services related to your treatment, case management or care coordination or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law
We may use or disclose your health information when we are required to do so by law.

Public Health
We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Notice of Privacy Practices (continued)

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

Appointment Reminders
We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

Sign-In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

Disclosure Accounting
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

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 of how payments will be handled under the alternative means or location you request.

Breach Notification
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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.

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: ____________________

Telephone: ____________________ Fax: ____________________

Email: ____________________

Address: ____________________

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint. **Arash Aftabi DMD complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.**

ARASH AFTABI, D.M.D., INC.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ____________________ E-mail: ____________________

Patient Number: ____________________ Social Security Number: ____________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Karen Demeduk

Telephone: (562) 431-4200 Fax: (562) 431-6134

Address: 13001 Seal Beach Blvd. Suite 310 Seal Beach, CA 90740

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ______________________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________ Date: ____________________

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