HEALTH HISTORY & PATIENT INFORMATION

PATIENT'S NAME Last ______________ First ______________ Middle Init. _____ SEX: M / F BIRTHDATE ______________
ADDRESS ______________ PHONE: ______________
If Patient is a Minor, give Parent's or Guardian's Name ______________ TODAY'S DATE ______________

PLEASE CIRCLE OR WRITE IN THE APPROPRIATE ANSWER

Doctor Notes

1. Physician's Name ______________
   Address ______________
   Phone ______________
2. Are you under a physician's care? .... Yes No
   Since when: ______________ Why? ______________
3. When was your last complete physical exam? ______________
   Please list: ______________
4. Are you taking any medication? .... Yes No
   Please list: ______________
5. Are you allergic to any medications or substances? .... Yes No
6. Do you have any other allergies? .... Yes No
7. Do you have any problems with penicillin, antibiotics, local anesthetics (Novocain), or other medications? .... Yes No
8. Are you sensitive to any metals or latex? .... Yes No
9. Are you pregnant or suspect you may be? .... Yes No
10. Do you take any birth control medications? .... Yes No
11. Have you ever been treated for or been told you might have a heart disease? .... Yes No
12. Do you have a pacemaker or an artificial heart valve implant? .... Yes No
13. Have you ever had rheumatic fever? .... Yes No
14. Are you aware of any heart murmurs? .... Yes No
15. Do you have high or low blood pressure? .... Yes No
16. Have you ever had a serious illness or major surgery? .... Yes No
    If so, explain ______________
17. Have you ever had radiation treatment, chemotherapy for a tumor growth or other condition? .... Yes No
18. Do you have soreness, clicking or popping in your jaw joint? .... Yes No
19. Do you have inflammatory diseases, such as arthritis or rheumatism? .... Yes No
20. Do you have any artificial joint/prosthesis? .... Yes No
21. Do you have any blood disorders, such as anemia, leukemia, hemophilia, etc.? .... Yes No
22. Have you ever bled excessively after being cut or injured? .... Yes No
23. Have you ever received a blood transfusion? .... Yes No
24. Do you have stomach problems? .... Yes No
25. Do you have any kidney problems? .... Yes No
26. Do you have any liver problems? .... Yes No
27. Are you a diabetic? .... Yes No
28. Do you have asthma? .... Yes No
29. Do you or have you had any sexually transmitted diseases? .... Yes No
30. Are you HIV positive? .... Yes No
31. Do you have AIDS? .... Yes No
32. Have you had or do you test positive for hepatitis? .... Yes No
33. Do you or have you had tuberculosis? .... Yes No
34. Do you smoke, chew, use snuff or any other forms of tobacco? .... Yes No
35. Do you consume alcoholic beverages? .... Yes No
36. Do you habitually use controlled substances? .... Yes No
37. Is there anything else we should know about your health that we have not covered in this form? ... Yes No
    If so, explain to dentists ______________

I hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation and/or other medication necessary for dental treatment.

The Parent or Guardian is required to remain in the Dental Center during their child's dental treatment.

REVIEW OF HEALTH HISTORY

Initial Visit
Patient's (parent) Signature ______________ Date: ______________ Reviewed By: ______________

First Update
Any changes: ______________
Patient's (parent) Signature ______________ Date: ______________ Reviewed By: ______________

Second Update
Any changes: ______________
Patient's (parent) Signature ______________ Date: ______________ Reviewed By: ______________

Third Update
Any changes: ______________
Patient's (parent) Signature ______________ Date: ______________ Reviewed By: ______________

Dental history

What is the reason for your visit today?____

How long has it been since your last dental visit? ________________________________

Do you have discomfort at this time ?____

Are your teeth sensitive to any of the following?

Heat_____ Cold _____ Pressure_____ Sweets______

Have there been any injuries to your mouth, teeth or face?_________________________

Do you gag easily?____

Do your gums bleed easily?____

Have you ever had periodontal disease?_______________________________________

Do you have clicking, popping or pain when opening & closing your mouth?__________

Have you been treated for TMJ symptoms?____________________________________

Do you like the appearance of your teeth?_____________________________________

Is there anything else we should know about you or your health the we have not yet covered in this form?____

If so please explain:____

Consent for treatment:

I herby authorize the doctor or designated staff to take x-rays, study models, and any other diagnostic aid deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics and fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for complete recital of possible complications. Lastly, I agree to be responsible for payments for all services rendered on my behalf or my dependants. I understand that payment is due at time of service.

Patient's signature:________________________Date:_________

Received by:________

Patient's name:__________________________________

Guardian's signature:_____________________________Date:_________

Received by:________

PATIENT INFORMATION

Full Name____________________ Date of Birth____________ Age_________

SS#____________________ Name you would like to be called? _______________

E-Mail Addresses____

First primary
Home Address_______________________________________

City________________ State_______________ Zip Code_____________

Home Phone____________ Work Phone_____________ Cell Phone_____________

Gender: Male Female

Employer______________________ Spouse Employer_______________________

Emergency Contact________________ Phone_____________ Relationship_________

Whom May We Thank for Referring You? ___________________________

PRIMARY INSURANCE INFORMATION

Name of Insured___________________ Relationship to Patient_______________

Date of Birth_______________ SS#______________________

Employer_________________ Primary Insurance Carrier__________________

Address____________________ City____________ State_______ Zip_________

Phone#_______________ ID#_____________________ Group#_______________

SECONDARY INSURANCE INFROMATION

Name of Insured_____________________ Relationship to Patient_______________

Date of Birth___________________ Employer_________________________

Secondary Insurance Carrier_______________________

Address___________________ City_______________ State_______ Zip_________

Phone#________________ ID#_________________ Group#________________

PLEASE NOTE
Our office bills individuals in the same household under one account. If you must have separate accounts Please notify the front desk personnel. Payment is due upon receipt of services. As a courtesy to our patients we will file private dental insurance claims. However, the co-payment and any deductibles specified by your plan are due at the time of services. Please remember that you are ultimately responsible for payment of the fees in this office. Payments may be made by cash, check, and visa/MasterCard

Signature of patient___________________________ Date_____________________

FINANCIAL POLICIES

Thank you for choosing us as your dental care provider. We are committed to providing the highest quality of dental care available to all of our patients. Our main concern is that you receive the proper and optimal dental treatment necessary to restore your dental health. Please read and sign our financial policy so that we can avoid any misunderstandings regarding payment for services rendered. If you have any questions or concerns about our policy, do not hesitate to ask our front office staff.

1. **MISSED APPOINTMENTS:** We require **2 BUSINESS DAYS** notice for any appointment changes. For any missed appointment or change without two business days notice there will be a charge of **$50 per appt hour.**

Initials__________ Witness_____________ Date___________

2. **PAYMENT:** Payment is due at the time of service. We accept cash, checks, Master Card, Visa and Discover cards.
3. **FILING INSURANCE CLAIMS:** We process insurance claims as a courtesy to our patients. We are unable to guarantee payment as the contract is between you and your insurance company. We request the patient to pay their co-pay and any deductibles at the time of service.
4. **RESPONSIBILITY OF PAYMENT:** Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you, our patient, not the insurance company. Therefore, all charges are ultimately the patient's responsibility. Not all services are a covered benefit in all contracts; each insurance company and each contract is different. If your insurance company denies payment of a claim for any reason, you must settle your account personally. If payment is ultimately received from your insurance company after you have paid your bill, the insurance payment will be refunded to you.
5. **RETURNED CHECKS:** Returned checks and balances older than 45 days may be subject to additional collection fees and interest charges of 1.5% per month.

I understand that I am responsible for payment at the time of service. I further understand that I am responsible for any and all payments that may be denied or otherwise not paid by my insurance company.

Signature:______________________________ Date:___________________

HIPPA Notice of Privacy Practices

Saeid Badie, D.D.S.
1575 N. Swan Road, Suite 100
Tucson, Arizona 85712
(520) 325-3022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice or Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TOP) and for other purposes that are not permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1.Uses and disclosures or Protected Health Information Uses and disclosures of Protected Health Information. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to, to ensure that physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may requires that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training or medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect; food and Drug Administration requirements: legal Proceedings; Law enforcement: Coroners, Funeral Directors, and Organ Donation;

Research: Criminal Activity: Military Activity and National Security; Worker's Compensation: Inmates: required Uses and Disclosures: under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, you can inspect or copy the following records, psychotherapy notes, information complied in reasonable anticipation of or as civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that protects access to protected health information.

Your physician is not required to agree to a restriction that you may request, If physician believes it is in your best interest to permit use and disclose of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by altering means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to this notice alternatively i.e. electronically.

You may have the right to have your physician mend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive as accounting of certain disclosures we have made, if any, of your protected health information.
We reserved the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.
We are required by law to maintain the privacy of, and provide individuals with, this notice or our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at out Main Phone Number.

Signature below is only acknowledgement that you have received this Notice Or our Privacy Practices.

Print Name: ______________________________ **Date:** ____________

Signature: ________________________________