PERSONAL HISTORY

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Patient's Date of Birth: _____/_____/_____

Cell #: _____ Social Security Number: _____/_____/_____

How would you like us to communicate with you to verify or schedule appointments?

Home_____Cell_____ Texting_____ Email: _____ (check all that apply)

Email address: _____

Emergency Contact Name: _____ Number: _____

Insurance Information

Name of Dental Insurance: _____

Subscriber Name: _____ Birthdate: _____

ID#: _____ Group#: _____

Secondary Insurance? No: _____ Yes: _____ Provide information to receptionist.

How did you hear about us? _____

Are you willing to provide feedback on your experience here today? Yes_____ No_____

Please provide your Dental Insurance Card at your first appointment. We will scan the card for any future care. Please notify us if your coverage changes.

MEANINGFUL USE: In compliance with the HITECH Act (EHR) to attain Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. Your information is held in strict confidence outlined by HIPAA Federal law and Dr. Syed's policy.

Race:
___African-American
___American-Indian
___Arabic
___Asian
___Caucasian
___Filipino
___Hispanic
___Other
___Declined to Specify

Primary Language:
___Arabic
___Chinese
___English
___French
___Hindi
___Korean
___Russian
___Somalia
___Spanish
___Urdu
___Other_____

Ethnicity:
___Hispanic
___Non-Hispanic
___Declined to Specify

Tobacco Use:
Never: _____
Current Smoker: _____ Light: ____Medium: ____ Heavy: ____
Social Smoker: _____ Vapor: _____
Smokeless (Chew): _____ Ex-Smoker: _____ Year quit: _____
Are you interested in information on quitting? _____

Patient (or Parent) Signature: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

"HIPAA"

What is the HIPAA Privacy Rule?

In 1996, the Health Insurance Portability and Accountability Act or the HIPAA was endorsed by the U.S. Congress. The HIPAA Privacy Rule, also called the Standards for Privacy of Individually Identifiable Health Information, provided the first nationally-recognizable regulations for the use/disclosure of an individual's health information. Essentially, the Privacy Rule defines how covered entities use individually-identifiable health information or the PHI (Personal Health Information).

For more detailed information, visit: https://www.hhs.gov/hipaa/index.html/

Purpose of Consent: By signing this form, you consent to our use and disclosure of your PHI to carry out treatment, payment activities and all healthcare operations. This can include but is not limited to; insurance payments, referrals to outside healthcare providers, continuance of care and 3rd party vendors. (ex: Dental Lab)

Notice of Privacy Practices: You have the right to read our NOTICE OF PRIVACY PRACTICES. You may obtain a copy of practices, including any revisions by contacting our office.

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

Informed Consent: I have had full opportunity to read and consider the contents of this consent form and the 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 (PHI) to carry out treatment, payment activities and health care operations.

Please list any person you would like to have access to your PHI. (Example: Spouse, Grandparent, etc....)

_____

Patient (Parent/Guardian) Signature: _____Date: _____

Release of Information for Insurance Payment Purposes

I understand that services rendered to me by Dr. Syed are my financial responsibility and that the Provider will bill my insurance company, as a courtesy to me. I authorize my insurance company to pay my benefits directly to Dr. Syed and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-named assignee, and I have agreed to pay, in a current manner, any balance of professional service charges over and above this insurance payment. I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by the insurance company listed above. I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

Patient (Parent/Guardian) Signature: _____Date: _____

DENTAL HISTORY

Previous Dental Information:

Date of last Dental Visit: _____ Date of last X-rays taken: _____

Are you satisfied with your past dentistry? Yes____ No____

Were you told of any needed dental work that hasn't been done yet? Yes____ No____

Do you have any fear or discomfort that has kept you from regular dental care? Yes___ No__

Do you have any goals for your Smile, Teeth and/or Dental Health?

_____

Are you interested in Teeth Whitening or Invisalign? _____

Have you ever had:

Orthodontic Treatment? ____
Periodontal Treatment? ____
TMJ/TMD Treatment? ____
Root Canal Treatment? ____
Serious injury to mouth or head? ____

Check any that apply:

Do your gums bleed or hurt? ____
Do you mouth breath? ____
Have you noticed mouth odors? ____

Have you ever experienced:

Clicking or popping of the jaw ____
Jaw Pain ____
Difficulty in opening/closing mouth ____
Tired jaw, especially in the AM ____
Clenching or grinding of teeth ____
Sensitivity to cold, hot, or sweet foods ____
Frequent cold sores, blisters or canker sores ____
Restless sleep or sleep apnea ____
Any other issues you'd like to talk about?

_____

How often do you:

Brush: _____
Floss: _____

MEDICAL HISTORY

Patient Name: _____

Have you had any surgeries? If yes, list surgery name and the year.

_____

Do you have any adverse reactions to any medication? If yes, list:

_____

LIST ALL MEDICATION YOU ARE PRESENTLY TAKING (Including prescriptions, over-the-counter and herbal)

_____ _____ _____

_____ _____ _____

Have you been advised by your medical doctor to premedicate with an antibiotic prior to having dental work?

Yes: _____

No: _____

DO YOU HAVE OR HAVE EVER HAD OR ARE BEING TREATED FOR ANY OF THE FOLLOWING?

YES	NO		YES	NO	
		Anemia/Blood Disorder			High Blood Pressure
		Angina Pectoris			Immunosuppressive Disorder
		Artificial Heart Valve			Implants
		Artificial Hip or Joint			Kidney Disease
		Arthritis			Leukemia
		Asthma			Low Blood Pressure
		Cancer/Malignancies			Nervousness
		Chemical Dependency			Osteoporosis
		Chemotherapy			Psychiatric Care
		Chronic Ear Infections			Radiation Treatments
		Congenital Heart Lesions			Rheumatic Fever
		Congestive Heart Failure			Sinus Problems
		Diabetes			Smoking/Vapor
		Emotional Stress			Stroke
		Emphysema			Thyroid Disease
		Epilepsy			Tuberculosis
		Eye Disorder/Glaucoma			Ulcers
		Fainting Spells			Venereal Disease/Herpes
		Heart Disease	LIST ANY AND ALL ALLERGIES:		
		Heart Murmur			
		Heart Pacemaker			
		Hemophilia			
		Hepatitis/Liver Disease			

FOR WOMEN: PREGNANT? YES____NO____ USING BIRTH CONTROL? YES____ NO____

Patient or Legal Guardian Signature: _____