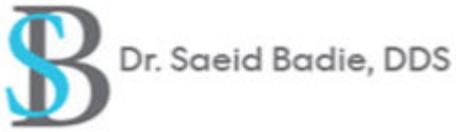

PATIENT INFORMATION

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_____

Cell Phone_____ Home Phone_____ Work Phone_____

Gender: Male Female Marital Status: Single Married Other

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_____

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 hereby 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 dependents. 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'S NAME _____ DATE OF BIRTH _____

PHYSICIAN'S NAME _____ PHYSICIAN'S ADDRESS _____ PHYSICIAN'S PHONE _____

MOST RECENT VISIT TO PHYSICIAN _____ REASON _____

HOW WOULD YOU ASSESS YOUR GENERAL HEALTH? o GOOD o FAIR o POOR

OFFICE USE ONLY

	Yes	No
PRE-MED	O	O

COMMENTS:

DATE _____

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

Are you currently seeing a physician for treatment of a recent or ongoing medical condition? o

Have you been hospitalized within the last year? If yes, explain:

Have you had a serious illness or operation within the last year? If yes, explain: o

Have you ever had any serious medical trouble Associated with any dental experience? If yes, explain:

Have you ever been advised to take antibiotics (like penicillin, etc.,) before a dental appointment? If yes, explain:

Do you now or have you had any of the following cardio-vascular diseases? yes o **no** o

If yes, check any that apply:

o Heart disease
o Heart attack
o Coronary bypass
o Angina
o Mitral valve prolapse
o Rheumatic fever or rheumatic heart disease
o Congenital heart defects
o Prosthetic (artificial) heart valves
o Pacemaker. If yes, date of placement _____
o High blood pressure
o High cholesterol
o Shortness of breath after mild exercise
o Shortness of breath when you lie down
o Swelling of ankles
o Chest pain upon exertion
o Abnormal bleeding or extended clotting time
o Frequent or unexpected nose bleeds

Diabetes yes o **no** o

If yes, do you require insulin?
Type _____ Dose_____

Artificial joint(s) yes o **no** o If yes, which joint(s) _____

Hepatitis yes o **no** o

If yes, check type:
o Type A
o Type B
o Type C
o Other
o Non-specific type
o Don't know

o Required a blood transfusion
If yes, when_____

o HIV positive
o Have reason to suspect you have been exposed to the HIV virus

Tuberculosis (TB) **yes** o **no** o
o Had a TB test?
o A cough lasting more than three weeks
o Cough up blood

Check any that apply;

o Allergies
o Alzheimer's
o Anemia
o Angina
o Asthma
o Arthritis
o Autoimmune
o Blood Disorder
o Cancer
o Chemo Therapy
o Chronic Sinus
o Cirrhosis
o Depression
o Diabetes
o Drug/Alcohol
o Treatment
o Eating Disorder
o Epilepsy/Seizures
o Glaucoma
o Heart Disease
o Herpes
o HIV / AIDS
o Jaundice
o Joint Replacement
o Kidney Disease
o Organ Transplant
o Osteoporosis
o Parkinson's
o Radiation
o Treatment
o Severe Headaches
o Sexually Transmitted Disease
o Skin Problems
o Tuberculosis
o Ulcers

	Yes	No
Do you consider yourself currently under an *abnormally* high amount of stress?	o	o
Have you had an unexplained or unplanned weight loss recently?	o	o

When was your last complete physical exam with your physician, including blood tests? _____

Do you now or have you ever smoked?	o	o

If you currently smoke, how much? _____
If you were a smoker, when did you quit? _____

Do you chew tobacco?	o	o

If yes, how often? _____

Do you drink alcohol?	o	o

If yes, how much? _____

W O M E N O N L Y

	Yes	No
Are you currently pregnant?	o	o

If yes, expected delivery date _____

Do you have regular gynecological checkups?	o	o
Have you reached menopause?	o	o
Are you on hormone replacement therapy?	o	o
Have you had a mammogram?	o	o

Date _____

If you *currently* take these medications, check the box on the left. If you have taken any of these medications within the <u>past year</u>, but are not taking them currently, check the box on the right.

o Antibiotics	o
o Antidepressants (Prozac, Zoloft, etc.)	o
o Antihistamines	o
o Blood pressure medication	o
o Blood thinners	o
o Cortisone (Prednisone)	o
o Cholesterol medication	o
o Decongestants	o
o Diuretics (water pills)	o
o Hormones (birth control, estrogen)	o
o Inhalants	o
o Insulin	o
o Heart medication / nitroglycerine	o
o Muscle relaxants	o
o Pain medication (Aspirin, Advil, Tylenol)	o
o Sleeping pills	o
o Thyroid medication	o
o Tranquilizers	o
o Vitamins	o
o Others	o

Are you *ALLERGIC* to any of the following (get hives, a rash, have trouble breathing, etc.):
o Antibiotics (penicillin, tetracycline)
o Local dental anesthetics (Novocain)
o Codeine
o Aspirin
o Barbiturates or sedatives
o Tranquilizers
o Others

	Yes	No
Have you ever had an adverse reaction (nausea, dizziness) with any drug or medication?	o	o
Do you have any disease, condition or medical problem not listed you feel we should know about?	o	o

List Prescriptions Medications & Reason

_____

_____

_____

_____

_____

S I G N A T U R E S

_____
Patient Signature

_____
Date

_____
Provider Signature

_____
Date

NOTES:

_____
_____
_____

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 ANOUT 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 practiced health information (PHI) to carry out treatment, payment or health care operations (TOP) and for other purposes that are not permitted or requited 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** Used and disclosures of Protected Health Information. You 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 admissions

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the nosiness 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 nosiness 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 or your appointment.

We may use or disclose your protected health information in the following situations without your authorization. This situation includes: 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 Donations; research: Criminal Activity: Miliary 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 of 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 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 meanis 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 for 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 disclosers 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 our Main Phone Number.

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

Print Name: _____ Dates: _____

Signature:_____

CANCELLATION POLICY

RESTORATIVE AND HYGIENE APPOINTMENTS

We ask for at least 48 hours advance notice for canceling or rescheduling an appointment, otherwise a $50 fee per hour may be assessed to your account.

Note: All Cancellation fees must be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people ---the patient who missed the valuable time, the patient who could have taken the evaluable time, and the doctor who was fully staffed and prepared for the appointment

_____ _____

Signature Date

ACKNOWLEDGEMENT AND RELEASE

Insurance

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, however the dentist's treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company, therefore we do not confirm insurance eligibility or predetermine recommended treatment. We are not preferred providers or members or have any association with any insurance organizations.

Collections

In the event the balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency and other legal expenses related to collection of fees owed. Waiver of any breach of condition shall not constitute a waiver of any further term or condition.

_____ _____

Signature Date

DENTAL INFORMATION RELEASE FORM (HIPPA RELEASE)

Name: _____ **Date of Birth**: _____

General Release of Information

I authorize this dental office to release and / or discuss any of my written records (including x-rays), confidential information, treatment, financial aspects, and all other material to the person(s) indicated below: check the appropriate box or boxes)

Name: _____ Release Records ☐ Discuss ☐
Phone: _____ Leave a message ☐ Voice ☐
E-mail: _____ Text ☐

Name: _____ Release Records ☐ Discuss ☐
Phone: _____ Leave a message ☐ Voice ☐
E-mail: _____ Text ☐

Name: _____ Release Records ☐ Discuss ☐
Phone: _____ Leave a message ☐ Voice ☐
E-mail: _____ Text ☐

Information may NOT be released to anyone but me ☐

How to Contact Me

The dental office may contact me or another person via the following methods:

Phone ☐ Message ☐ Text ☐
E-mail ☐
Other Phone:_____ Message ☐ Text ☐

I may amend or revoke any part of the HIPPA release at any time, but only in writing.

Any duplication of records will result in a $25.00 fee unless the records are for a specialty office.

Signature _____ Date _____