

# 1

## PATIENT INFORMATION

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

M.I. \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Who/what referred you to our office? \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Divorced  Married  
 Separated  Single  Widowed

Birthdate (MM/DD/YYYY) \_\_\_\_\_

Social Sec.: \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to receive a text message from us to remind you of your appointment?  Yes  No

Check all that apply. This person is the:

Patient  Policy Holder  Responsible Party

# 2

## INSURANCE INFORMATION

Name of Policy Holder \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Divorced  Married  
 Separated  Single  Widowed

Birthdate (MM/DD/YYYY) \_\_\_\_\_

Social Sec.: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Name of Employer** \_\_\_\_\_

**Address of Employer** \_\_\_\_\_

**Employer Tel. No.** \_\_\_\_\_

Primary Insurance

Insurance Co. Name \_\_\_\_\_

Group Number \_\_\_\_\_

Member ID Number: \_\_\_\_\_

# 3

## RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT INFORMATION)

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ **Name of Employer** \_\_\_\_\_

Home Phone \_\_\_\_\_ **Work Phone** \_\_\_\_\_

Cell Phone \_\_\_\_\_ Sex:  Male  Female

Marital Status:  Divorced  Married Birthdate (MM/DD/YYYY) \_\_\_\_\_

Separated  Single  Widowed Social Sec.: \_\_\_\_\_

# 4

## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I authorize the professional office of my dentist, (Dr. Saqib H. Mohajir – Optima Dental Associates, LLC) to release all necessary health information identifying me to the following recipients only:

- 1.) My primary care physician, and/or medical/dental specialists, to aid in the diagnosis or treatment of my medical or dental health.
- 2.) My insurance company, to allow for payment of any claims made by this office toward my dental care. I assign all insurance benefits, otherwise payable to me, to the treating doctor for services rendered. I authorize the use of the signature below on all insurance submissions.

I HAVE READ AND UNDERSTAND THE ABOVE FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Dated \_\_\_\_\_ **Patient/Parent (circle one) signature** \_\_\_\_\_

If you are signing as a representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_

**PLEASE PROVIDE LICENSE/ID CARD AND INSURANCE CARD TO OFFICE REPRESENTATIVE**

# Patient Medical History

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you on special diet?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you had any metal rods, pins or implants placed?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you use tobacco?  Yes  No If yes, how much? (pack/day) \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

## MEDICATIONS

 List any medications, pills or drugs you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

## ALLERGIES

 Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  
 Acrylic  Metal  Local Anesthetics  
 Latex  Other If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

- Women:** Are you?  Pregnant  Trying to get pregnant  
 Nursing  Taking oral contraceptives

## HEALTH HISTORY

 Do you currently have, or have you ever had, any of the following conditions?

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rashes       | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

NAME OF PATIENT \_\_\_\_\_ DOB \_\_\_\_\_

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# PRIVACY POLICY

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.

We understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information. PHI includes individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for such health care. We use and disclose PHI about you for treatment, payment, and health care operations.

**Treatment:** We may disclose PHI to your insurance provider, our dentist(s), and other dental care providers for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seeks information from your insurance provider as to whether the service has been previously provided.

**Payment:** We disclose your PHI in order to fulfill our duty to check your coverage, determine your benefits, and secure payment for services provided to you. For example, we use your PHI in order to request process of your claims by your insurance provider.

**Health Care Operations:** We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed. We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law. We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment, and health care operations).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

**Individual Rights:** In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment, or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your PHI for treatment, payment, and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations if you clearly state that disclosure of all or part of your PHI could endanger you.

**Complaints:** If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed above. You may also send a written complaint to the U.S. Department of Health and Human Services. Customer Service can provide you with the appropriate address upon request.

**Our Legal Duty:** We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or concerns, please contact our office.

# Financial Policy

At Optima Dental Associates, our ultimate goal is your dental health and wellness. That's why we always present you with the best dental solutions possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental insurance benefits but some do not. If you have dental benefits, congratulations! You are extremely fortunate. Here are some important points you should know:

## Initial

- \_\_\_\_\_ • Your dental benefits are based upon a contract made between you and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans **will never pay for completion of your dental care**. They are meant only to assist you.
- \_\_\_\_\_ • We currently accept a large number of PPO insurance plans. This means we work with literally hundreds of companies. Although we can maintain computerized histories of payments by a given company, they do change; therefore it is **impossible to give you a guaranteed quote** at the time of service. We estimate your portion based on the most up-to-date information we have but it is **ONLY AN ESTIMATE**. If you would like exact out of pocket figures, we can submit a "pre-treatment authorization" with your insurance company. Keep in mind this is not a guarantee of coverage and it may delay treatment.
- \_\_\_\_\_ • We will bill your insurance company as a courtesy. If insurance does not pay within 90 days, Optima Dental Associates reserves the right to request payment in full for services from you and let you collect the insurance funds due to you. **This is rare**, but it is important that you recognize that the insurance you have is a legal contract between **YOU** and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, **you are responsible for all charges incurred in our office**.
- \_\_\_\_\_ • Optima Dental Associates does require payment in full for your portion **at the time of service**. We accept MasterCard, Visa, American Express, Discover, cash and checks. If you are in need of payment plans, we also work with CareCredit which offers 6 or 12 month "same as cash" no interest financing. Our staff can assist you in the application process.
- \_\_\_\_\_ • A specific amount of time is **reserved especially for you** and we strongly encourage all patients to keep their appointments. If you must change your appointment, **we require at least 24 hours notice to avoid a cancellation fee of at least \$25**.

**I have read and agree with the above conditions.**

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Patient/Parent signature \_\_\_\_\_