PATIENT INFORMATION

NAME:_________________________BIRTHDATE:_______________AGE_____GENDER_______________
ADDRESS__________________________________ APT#_______CITY____________STATE____________
ZIPCODE____________ SSN_____-_____-_____
PHONE NUMBERS: HOME_______________ WORK___________________ CELL__________________
EMAIL ADDRESS__________________________________
EMERGENCY CONTACT__________________RELATIONSHIP_______________PHONE_______________
WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?_____________________________________

PERSON RESPONSIBLE FOR ACCOUNT IF DIFFERENT THAN THE PATIENT

NAME____________________________BIRTHDATE______________ AGE_________GENDER__________
ADDRESS_________________________APT#_______CITY____________STATE________ZIPCODE_______
SSN_____-_____-_____PHONE NUMBERS: HOME___________WORK_____________CELL____________

EMPLOYER INFORMATION

(PLEASE FILL THIS OUT, THIS IS FOR INSURANCE PURPOSES)

EMPLOYER'S NAME:_______________________________PHONE NUMBER_________________________
ADDRESS:_______________________SUITE________CITY_____________STATE________ZIP__________

INSURANCE INFORMATION

NAME OF POLICY HOLDER:________________________________PHONE NUMBER__________________
INSURANCE COMPANY_____________________________ID#/SSN_________________________________
INSURANCE PHONE NUMBER:__________________________GROUP#____________________________
POLICY HOLDER'S RELATIONSHIP TO PATIENT: SELF / SPOUSE / CHILD / OTHER (circle one)

DENTAL HISTORY

WHAT IS THE REASON FOR THE APPOINTMENT?____
ARE THERE ANY SPECIFIC DENTAL PROBLEMS WE SHOULD BE AWARE OF?__________________________
DO YOU THINK YOU HAVE ANY DECAY CAVITIES?___YES___NO
HOW OFTEN DO YOU BRUSH?_______________FLOSS?____
DO YOUR GUMS BLEED EASILY WHEN BRUSHING AND/OR FLOSSING?__YES__NO
DO YOU SUFFER FROM CHRONIC BAD BREATH OR BAD TASTE?__YES__NO
DO YOU HAVE ANY JAW JOINT CRACKING OR PAIN?__YES__NO
WHAT WAS THE PURPOSE OF YOUR LAST DENTAL APPOINTMENT?_______________________________
WHEN WAS THAT?______________________________
WHEN WERE THE LAST FULL MOUTH X-RAYS TAKEN OF YOUR MOUTH?
WHEN WAS YOUR LAST DENTAL CLEANING?___________NAME OF PREVIOUS DENTIST?_____________
HOW WOULD YOU DESCRIBE YOUR DENTAL HEALTH?______EXCELLENT__GOOD__FAIR__POOR
DO YOU NEED TO TAKE ANTIBIOTICS PRIOR TO DENTAL APPOINTMENTS?__YES__NO
IS A PHYSICIAN CURRENTLY TREATING YOU?__YES__NO
PHYSICIANS NAME / ADDRESS / PHONE ____
PLEASE LIST ANY MEDICATION, PILLS, OR TONICS YOU ARE TAKING:
_____________________FOR____FOR_____________________
_____________________FOR____FOR_____________________

MEDICAL HISTORY

INFORMATION THAT YOU FEEL INSIGNIFICANT COULD BE DIRECTLY RELATED TO YOUR DENTAL HEALTH ANSWERING THE FOLLOWING QUESTIONS WILL PROVIDE US WITH A THOROUGH UNDERSTANDING OF YOUR PHYSICAL CONDITION FOR PROPER RECOMMENDATIONS REGARDING YOUR DENTAL CARE. THIS INFORMATION IS STRICTLY CONFIDENTIAL. THANK YOU FOR COMPLETING ALL QUESTIONS IN DETAIL.

DO YOU HAVE OR HAVE YOU BEEN TREATED FOR THE FOLLOWING? CHECK ALL THAT APPLY

- ☐ ANY HEART PROBLEMS
- ☐ HEART MURMUR
- ☐ MITRAL VALVE PROLAPSE
- ☐ MITRAL VALVE DEFECT
- ☐ HEART VALVE REPLACEMENT
- ☐ RHEUMATIC FEVER
- ☐ ARTIFICIAL JOINT (HIP/KNEE)
- ☐ ANGINA
- ☐ STROKE
- ☐ HEART ATTACK
- ☐ BYPASS
- ☐ PACEMAKER
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ ANY BLEEDING DISORDERS
- ☐ ANEMIA
- ☐ HEMOPHILIA
- ☐ SICKLE CELL TRAIT
- ☐ BLOOD TRANSFUSIONS
- ☐ DO YOU SMOKE
- ☐ LUNG BREATHING PROBLEMS
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ EMPHYSEME
- ☐ TUBERCULOSIS
- ☐ SINUS TROUBLE
- ☐ DIFFICULTY IN HEALING
- ☐ DIABETES
- ☐ THYROID PROBLEMS
- ☐ ADRENAL/PITUITARY PROBLEMS
- ☐ LIVER PROBLEMS/DYSFUNCTION
- ☐ HEPATITIS/JAUNDICE
- ☐ KIDNEY PROBLEMS/DYSFUNCTION
- ☐ STOMACH TROUBLE/ULCERS
- ☐ NERVOUS OR MENTAL DISORDERS
- ☐ EPILEPSY OR SEIZURES
- ☐ ALCOHOLISM
- ☐ DRUG ABUSE
- ☐ SLEEP APNEA (SNORING)

ALLERGIES

CHECK ALL THAT APPLY

- ☐ PENICILLIN
- ☐ ERYTHROMYCIN
- ☐ SULFA
- ☐ CODEIN
- ☐ ASPIRIN
- ☐ LATEX
- ☐ LOCAL ANESTHETIC (XYLOCAINE)
- ☐ ANY OTHER ALLERGIES___________________

OTHER

- ☐ CANCER/TUMORS
- ☐ OTHER GROWTHS
- ☐ CHEMOTHERAPY/RADIATION
- ☐ SEXUALLY TRANSMITTED DISEASES
- ☐ HIV/AIDS
- ☐ ARE YOU PREGNANT?

ARE THERE ANY CONDITIONS OR PROBLEMS RELATING TO YOUR MEDICAL HISTORY THAT WAS NOT MENTIONED? ◯ YES ◯ NO
(IF YES EXPLAIN)____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I WULL INFORM THE DOCTOR OF ANY CHANGES IN MY MEDICAL HEALTH STATUS OR MEDICATIONS.
PATIENT/GUARDIAN SIGNATURE________________________(SEAL) DATE_________________________

PATIENT TREATMENT CONSENT

I AUTHORIZE THE DENTIST (S) OR DESIGNATED STAFF TREATING ME TO PERFORM SUCH DIAGNOSTIC AIDS DEEMED APPROPRIATE TO MAKE A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS UPON DIAGNOSIS. I AUTHORIZE THE DENTIST (S) TO PERFORM ALL RECOMMENDED TREATMENT AND THERAPEUTIC PROCEDURE TO INCLUDE ADMINISTERING MEDICATIONS AS PRESCRIBED BY THE DENTIST (S) AND MUTUALLY AGREED BY ME.

I ASSIGN ALL DENTAL INSURANCE BENEFITS TO WHICH I AM ENTITLED TO THE EXTENT PERMITTED UNDER MY DENTAL INSURANCE POLICY (S) TO THE DENTIST. THIS FORM ALSO AUTHORIZES THIS PRACTICE TO SUBMIT INSURANCE CLAIM FORMS AND RECEIVE PAYMENT DIRECTLY FROM THE INSURANCE CARRIER WITH THE NOTATION “SIGNATURE ON FILE”. I AUTHORIZE MY DENTIST TO RELEASE RECORDS/X-RAYS OR ANY OTHER INFORMATION DEEMED PERTINENT TO MY INSURANCE CARRIER AS NECESSARY AND / OR REQUEST.

I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICE RENDERED ON MY BEHALF OR MY DEPENDANTS. I AGREE THAT ANY UNPAID CLAIMS THE CARRIER DOES NOT PAY OR ANY BALANCE THAT EXTENDS BEYOND 60 DAYS FROM THE DATE OF TREATMENT WILL BE ASSESSED A SERVICE CHARGE OF 1 ½ % PER MONTH.

IN THE EVENT THAT THE STAFF IS PUNCTURED OR CUT BY ANY INSTRUMENTS USED ON ME. **I AGREE TO TAKE BLOOD TEST TO VERIFY THAT THE STAFF WAS NOT INFECTED WITH ANY INFECTIOUS DISEASES.**

PATIENT/PARENT OR GUARDIAN SIGNATURE__________________________ (SEAL) DATE_______________

A COSMETIC AND FAMILY CLINIC

ROZITA SAFAVIZADEH D.D.S.

14820 PHYSICIANS LANE, SUITE 141

ROCKVILLE, MD 20850 (301) 838-8725

NOTICE OF PRIVACY PRACTICES, (HIPPA)

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.

UNDERSTANDING YOUR HEALTH RECORD /INFORMATION

Each time you visit our office; a record of our visit is made. Typically, this record contains your symptoms, examination result, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your dental record, serves as a basis for planning your care. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy that we maintain in our practice concerning your protected health information (PHI).

YOU'RE HEALTH INFORMATION RIGHTS:

Unless otherwise required by law your health record is the physical property of the healthcare practitioner or the facility that compiled it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information and request amendments to your health record. All your requests must be in writing and contain a reason supporting your request. We may deny your request if you ask us to amend information that is in our opinion: a) accurate and completed; b) not part of the PHI kept by or for the practice; c) net part of the PHI which you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information in not available to amend the information. This includes the right to obtain a paper copy of the notice of information practices upon request, inspect and obtain a copy of your health record. Obtain an accounting of disclosures of your health information such as the doctor's communication with your insurance company of the billing department, request communications of your health information by alternatives means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

We are required to maintain the privacy of your health information. In addition, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This practice must abide by the terms of this notice, notify you if we are unable to agree to requested restrictions, accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will notify you.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact Dr. Rozita Safavi at (301) 838-8725. If you believe your privacy rights have been violated, you can file a complaint with the secretary of health and human services. There will be no retaliation for filling complaint.

EXAMPLES OF DISCLOSURE FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

We will use your health information for treatment. For example, Information obtained by a healthcare provider will be recorded in our record and used to determine the course of treatment that should work best for you. We may also provide our other practitioners with copies of various reports that should assist them in treating you. For example: If you need to be seen by a specialist or another healthcare provider.

We will use your health information for payment. For example: bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Business Associates: There may be some services provided in our practice through contracts with Business Associate. Examples include physician's services in the emergency department, certain lab test, dental laboratories, copy services we may use to copy your health record, and the collection agencies for payment, if needed. When these services are contracted, we may disclose some or all of your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to apply safeguard your information.

Notifications: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location; and general condition.

Please note our office communicates with the specialists involved in your treatment and also with insurance companies electronically.

Communication with family: Health professionals, using their best judgment, may disclosed to a family member, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Marketing: We may contact you to provide appointment reminders.

Food and Drug Administration (FDA): As required by law; we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects.

Workers compensation: We may disclose your health information for workers compensation and similar programs to the extent required by law.

Public health: As required by law we may disclose your health information to public health or legal authorities charged with tracking birth and deaths, as well as with preventing or controlling disease, injury or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the notice of privacy practices.

Lawsuits and similar proceedings: Our practice may use and disclose your health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceedings. We may also disclose your PHI in response to a subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or obtain an order protecting the information the party has requested.

Military: Our practices may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

National Security: Our practices may disclose you PHI to federal officials for intelligence and national security activities authorized by law.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: This notice will be prominently posted in the office.

EFFECTIVE DATE: APRIL 14, 2003

I WAS PROVIDED AND HAVE READ THE ABOVE NOTICE.

SIGNATURE: ______________________________ **DATE:** ____________________

NAME: ______________________________

A COSMETIC AND FAMILY CLINIC LLC
ROZITA SAFAVIZADEH DDS
14820 Physicians Lane, Suite 141 Rockville, MD 20850 (301) 838-8725

We welcome you to the dental practice of Dr. Rozita Safavizadeh. We are committed to provide you with the best possible dental care at the lowest cost. Since our practice also has financial obligations which must be met, we ask that all patients pay for their examinations and treatment in full on the same day of their visit.

In the event that you're insurance coverage changes to a plan which we are not participating providers, you will be responsible for payment of all fees at the time of service. Please be aware that few insurance companies attempt to cover all dental costs. Some pay fixed allowances for each procedure while others only pay a percentage of the costs. Our practice is committed to provide the best patient care and our fees are compatible with the usual and customary fees in the area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates which may bear no relationship to the current standard and cost of care in this area. We need your assistance and understanding of our payment policy as follows:

1. All patients are responsible to make sure their bills are paid in a timely manner. For your convenience, we accept VISA, MASTERCARD and DISCOVER. You are also welcome to pay with check or cash. There will be a $35 fee for all returned checks.
2. As a courtesy to you, we will bill your insurance company if you provide us with the correct policy or claim numbers, same of insured and exact address at the time of you visit. **We will not accept multiple insurance plans unless prior arrangement has been made with our billing department.** There is a $100 deposit required if you are not able to give us your insurance information prior to seeing the Doctor.
3. We will allow 45 days for your insurance company to make payment. Your insurance company may require additional information from you before they process the claim. Please respond promptly to their request. You **will be expected to pay our balance if your insurance has not paid in 45 days.**
4. All insured patients are asked to review their particular guidelines. Coverage may vay among individual groups. We may not be aware of rules unique to your group. We make every effort to provide the care you need within your plan rules. Please do not ask to be treated without the proper insurance information. **All HMO patients are required to pay their co-payments at the time of service**. While each patient's dental problems differ and it is often impossible to estimate the total cost of services before they are rendered, it is advisable that you obtain estimate on all treatment plans whenever possible so that you are aware in advance as to what your co-pay might be.
5. Original dental records and X-Rays are part of your permanent dental record and must remain in our office. Copies of dental records and X-Rays may be obtained with no less that 21 days advance written notice. Costs are established in accordance with the Maryland State Board of Medical Examiners. The current rate is $15 for retrieval and preparations of records, $.50 per page for copying and &1.00 for each bite wing or periapical film, $4.00 for panoramic film and the actual coast of postage should it apply. The fee must be paid prior to receiving your copy.
6. A Cosmetic and Family Clinic requires payment at the time of service. All balances over 30 days will be charged 1.5% per month. If it is necessary to turn your account over to collection, your fees for service will be adjusted to reflect our full UCR and there will be an additional charge of 1/3 of your total balance to cover attorney fees. All court costs and any other cost associated with collection of this account will be your responsibility.
7. **Cancellation of appointments is required 24 hours in advance.** It is the policy of this office to charge $50.00 per half hour of any appointment missed or cancelled less than 24 hours.

   Our practice believes that a good Dr./Patient relationship is based upon understanding and good communication. If you have any questions regarding financial arrangements please feel free to speak to our office manager. We will make every effort to answer any questions you might have about your account of this agreement. We are here to help you and we are happy to have you in our family of patients.

   I have read and understood the above financial policy and accept financial responsibility for services rendered.

   Patient/Guardian Signature:______________________________ (SEAL) DATE: ___________