5 HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			
Do you wear contact lenses?	☐ Yes	☐ No						

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Rajinder Singh Bhullar, DDS, PA

10905 Fort Washington Road, Suite 207, Fort Washington, MD 20744

Rajinder Singh Bhullar, DDS, PA Financial Policy

- Payment for services are due in full, at the time services are started. Meaning services that require multiple visits are to be paid in FULL on the first visit.
  - Initial _____ (staff _____)

- We file your dental claim to your insurance company at no cost and as a courtesy to you. We will provide you with the closest estimate for your services. The estimate is not a guarantee of payment. Insurance companies may pay more (patient would be due a refund) and may pay less (patient will receive an invoice/statement) than estimated. If the insurance company does not pay in full the remaining unpaid balance is and will be patient responsibility.
  - Initial _____ (staff _____)

- Dr. Bhullar strives to be on time and respect our patients time. We require the same in return, and reserve the right to place scheduling stipulations on any patient account that we deem necessary. Example stipulations; a) require prepayment to schedule, b) only allow for 2 patients in the same family to schedule on the same day, ect.
  - Initial _____ (staff _____)

- There is a 24 hour notice required to change your appointment date/time. Any Broken Appointments or No Shows will result in a $40.00 (appointments 30 minutes or less), $60.00 (appointments 60 minutes to 90 minutes) and $80.00 (appointments 91 minutes or more) fee being charged to your account. The fee assessed MUST be paid BEFORE making any further appointments and any other appointments you may already have may be canceled (office discretion will be used). Saturday appointments require a 48 hour notice to change and the patients' ability to schedule on a Saturday will be revoked if the appointment is broken along with the above fee's.
  - Initial _____ (staff _____)

Rajinder Singh Bhullar, DDS, PA Financial Policy continued:

- Returned checks are subject to a fee of $50.00 per returned item.
  - Initial _____ (staff _____)

- Balances not paid in a timely manner will be placed for outside collection. Placement of accounts with a collection agency may affect your credit and will result in additional fees charged to your account which may include but are not limited to; attorney fees, court costs, interest with a rate of 18% per annum, collection agency fees of 33.33% of your account balance due, ect.
  - Initial _____ (staff _____)

I _____, have read and fully understand RSB, DDS, PA Financial Policy and Procedures. I have been given the opportunity to get clarification on anything I did not understand and I agree to all of the above terms and conditions.

_____ _____

Patient Name Patient DOB

_____ _____

Patient/Guardian Signature Relationship to Patient

_____

Date

Rajinder Singh Bhullar, DDS, PA

10905 Fort Washington Road, Suite 207, Fort Washington, MD 20744

HIPAA Notice of Privacy Practices

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 of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are 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.

Uses and disclosures of protected health information

Your protected health information may be used and disclosed by your physician, our office and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physicians practice, and any other use required by law.
Treatment: we will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare 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 ensure that the physician has necessary information to diagnose or treat you.
Payment: You're 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 require 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 of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose 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 disclosure of 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 requirement, 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 are compliant 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, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: 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, however, you may not inspect the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

HIPAA Privacy Cont.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. Your request must state the specific restriction requested into which you want the restriction to apply; your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your personal protected health information, your protected health information will not be restricted. You didn't have the right to use another healthcare professional. Do you have the right to receive confidential communications from us by alternative means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept his notice alternatively i.e. electronically.

You may have the right to have your physician amend 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 an accounting of certain disclosures we have made, if any, of your protected health information. We reserve 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 the secretary of health and human 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 is 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 of 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 acknowledgment that you have received this Notice of Privacy Practices.

Print Name: _____ **Signature:** _____ **Date:** _____

I (patient name) _____ authorize (name of authorized person) _____ to obtain my Dental Records on my behalf. I understand that if I decide to revoke this authorization that it must be done in writing and submitted to RSB, DDS, PA.

Relationship to authorized personnel is _____.

Date: _____ **Patient Signature:** _____