
Welcome to Moorpark Cosmetic and General Dentistry office. We are pleased you have chosen us for your dental health care. We are able to offer you and your family the high level of care you are looking for and a pleasant and relaxed environment.

We offer a full array of treatments in our office to bring you a beautiful, healthy smile. Our caring team will work with you to map out a dental plan that fits your personal needs, goals, and lifestyle.

Our services include:

- Cosmetic Dentistry
- Teeth Whitening
- Crowns
- Bridges
- Implant Crowns & Bridge
- Veneers
- Invisalign
- Root Canal Therapy

You can view a complete list of our dental services at our website:
www.moorparkcosmeticandgeneraldentistry.com

No matter the scope of your cosmetic dental problems, we will treat you with genuine concern and compassions. We want to be your life-long partner in dental health. Feel free to contact our office with any questions or concerns about any treatment (proposed or performed), fee for service, or professionalism of our dental team that you discuss it with us openly and promptly so that we maintain a positive relationship with our patients.

Sincerely,
Dr M. Salem and Staff


# Welcome Form & Emergency Contact Information

**ABOUT YOU:** Referred By: _____ Today's Date: ____/____/____

Name: _____ (First) _____ (Middle) _____ (Last)

Birthdate: ____/____/____ SS #: ____-____-____ ○Male ○Female

Address: _____ (Address) _____ (City) ____ (State) _____ (Zip Code)

Contact: (____)____-____ (Home Phone) (____)____-____ (Work Phone) (____)____-____ (Cell Phone) _____ (Email)

Employer: _____ Occupation: _____

Status: ○Minor ○Single ○Married ○Divorced ○Separated ○Widowed

Spouse's Name: _____ (First) _____ (Middle) _____ (Last)

**ACCOUNT INFORMATION:**

Responsible Party: _____ (First) _____ (Last) Relationship: _____

Address: _____ (Address) _____ (City) ____ (State) _____ (Zip Code)

Birthdate: ____/____/____ Social Security #: ____-____-____

Contact: (____)____-____ (Phone) (____)____-____ (Work Phone) (____)____-____ (Cell Phone)

**INSURANCE**

| | Primary Dental Insurance | Secondary Dental Insurance | Medical Insurance |
|---|---|---|---|
| Insurance: | | | |
| Subscriber: | | | |
| DOB: | | | |
| ID#: | | | |
| GRP.#: | | | |

**EMERGENCY CONTACT:**

Name: _____ (First) _____ (Last) Relationship: _____

Contact: (____)____-____ (Home Phone) (____)____-____ (Work Phone) (____)____-____ (Cell Phone)

Medical Doctor: _____ (First) _____ (Last) Doctor's Phone: (____)____-____

Doctor's Address: _____ (Address) _____ (City) ____ (State) _____ (Zip Code)

Previous Dentist: _____ (First) _____ (Last) Dentist's Phone: (____)____-____

Dentist's Address: _____ (Address) _____ (City) ____ (State) _____ (Zip Code)


## Medical History Questionnaire

Patient Name: _____ Birth Date: ____/____/____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that your may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

| | YES | NO | If yes, Please explain below |
|---|---|---|---|
| Are you under a physicians care right now? | O | O | |
| Have you ever been hospitalized or had a major operation? | O | O | |
| Have you ever had a serious head or neck injury? | O | O | |
| Are taking any medications, pills, or drugs? | O | O | |
| Do you take, or have you taken, Phen-Fen or Redux? | O | O | |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing biphosphonates? | O | O | |
| Are you on a special diet? | O | O | |
| Do you use tobacco? | O | O | |
| Do you use controlled substances? | O | O | |

| Women: Are you... | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Pregnant/Trying to get pregnant? | O | O | Taking oral contraceptives? | O | O | Nursing? | O | O |

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ Other (Please explain): _____

Do you have, or have you had, any of the following?

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | O | O | Cortisone Medicine | O | O | Hemophilia | O | O | Radiation Treatments | O | O |
| Alzheimer's Disease | O | O | Diabetes | O | O | Hepatitis A | O | O | Recent Weight Loss | O | O |
| Anaphylaxis | O | O | Drug Addiction | O | O | Hepatitis B or C | O | O | Renal Dialysis | O | O |
| Anemia | O | O | Easily Winded | O | O | Herpes | O | O | Rheumatic Fever | O | O |
| Angina | O | O | Emphysema | O | O | High Blood Pressure | O | O | Rheumatism | O | O |
| Arthritis/Gout | O | O | Epilepsy or Seizures | O | O | High Cholesterol | O | O | Scarlet Fever | O | O |
| Artificial Heart Valve | O | O | Excessive Bleeding | O | O | Hives or Rash | O | O | Shingles | O | O |
| Artificial Joint | O | O | Excessive Thirst | O | O | Hypoglycemia | O | O | Sickle Cell Disease | O | O |
| Asthma | O | O | Fainting Spells/Dizziness | O | O | Irregular Heartbeat | O | O | Sinus Trouble | O | O |
| Blood Disease | O | O | Frequent Cough | O | O | Kidney Problems | O | O | Spina Bifida | O | O |
| Blood Transfusion | O | O | Frequent Diarrhea | O | O | Leukemia | O | O | Stomach/Intestinal Disease | O | O |
| Breathing Problem | O | O | Frequent Headaches | O | O | Liver Disease | O | O | Stroke | O | O |
| Bruise Easily | O | O | Genital Herpes | O | O | Low Blood Pressure | O | O | Swelling of Limbs | O | O |
| Cancer | O | O | Glaucoma | O | O | Lung Disease | O | O | Thyroid Disease | O | O |
| Chemotherapy | O | O | Hay Fever | O | O | Mitral Valve Prolapse | O | O | Tonsillitis | O | O |
| Chest Pains | O | O | Heart Attack/Failure | O | O | Osteoporosis | O | O | Tuberculosis | O | O |
| Cold Sores/Fever Blisters | O | O | Heart Murmur | O | O | Pain in Jaw Joints | O | O | Tumors or Growths | O | O |
| Congenital Heart Disorder | O | O | Heart Pacemaker | O | O | Parathyroid Disease | O | O | Ulcers | O | O |
| Convulsions | O | O | Heart Trouble/Disease | O | O | Psychiatric Care | O | O | Venereal Disease | O | O |
| | | | | | | | | | Yellow Jaundice | O | O |

| | YES | NO |
|---|---|---|
| Have you ever had any serious illness not listed above? | O | O |

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.

_____ ____/____/____

[SIGNATURE TO BE WITNESSED & COMPLETED AT DENTAL OFFICE] Date

M. Salem, DDS

# Acknowledgement of Receipt of Notice of Privacy Practices & Patient Welcome Packet

I, _____ _____ _____
First Middle Last

_____ _____/_____/_____
(SIGNATURE TO BE WITNESSED & COMPLETED AT DENTAL OFFICE) Date

## FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I, _____, acknowledge I have received a copy of the Dental Materials Fact Sheet dated October 2001 from Moorpark Cosmetic and General Dentistry.

_____ _____/_____/_____
(SIGNATURE) (DATE)

I _____, give permission to discuss my dental needs with my guardian.

_____
(NAME OF GUARDIAN)

_____ _____/_____/_____
(SIGNATURE) (DATE)

I have read, understood, and completed to preceding FIVE (5) page patient welcome packet as truthfully and to the best of my ability as possible.

_____ _____/_____/_____
(SIGNATURE TO BE WITNESSED & COMPLETED AT DENTAL OFFICE) Date

M. Salem, DDS

# NOTICE OF PRIVACY PRACTICES (2 Pages)

*We Care About Your Privacy*

## 1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is person and We are committed to protecting it. We create a record of the Care and services you receive at our organization. We need This record to provide your with quality care and to comply With certain legal requirements. This notice will tell you about The ways we may use and share medical information about You. We also describe your rights and certain duties we have Regarding the use and disclosure of medical information.

## 2. Our Legal Duty

**Law Requires Us to:**

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy Practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

**We Have the Right to:**

1. Change our privacy practices and the terms of this Notice at any time, provided that the changes are Permitted by law.
2. Make the changes in our privacy practices and the new Terms of our notice effective for all medical information That we keep, including information previously created or Received before the changes

**Notice of Change to Privacy Practices**

1. Before we make an important change in our privacy Practices, we will change this notice and make the new Notice available upon request.

## 3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use And disclose medical information. Not every use or disclo- Sure will be listed. However, we have listed all of the different Ways we are permitted to use and disclose medical informa- Tion. We will not use or disclose your medical information for Any purpose not listed below, without your specific written Authorization. Any specific written authorization you provide May be revoked at any time by writing us.

**For Treatment:**

We may use medical information about you to provide you With medical treatment or services. We may disclose medical Information about you to doctors, nurses, technicians, med- Ical students, or other people who are taking care of you. We May also share medical information about you to your other Health care providers to assist them in treating you.

**For Payment:**

We may use and disclose your medical information for Payment purposes. A Bill may be sent to you or a third-party Payer. The information on or accompanying the bill may Include your medical information.

**For Health Care Operations:**

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

**Additional Uses and Disclosures:**

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

***Facility Directory:***

Unless you notify use that you object, the following medical information about you will be placed in our facility directories your name; your location in our facility; your condition Described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to other who contact us and ask for information about you by name.

***Notification:***

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse per- mission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health infor- mation that is directly necessary for your health care, accord- ing to our professional judgment. We will also use our pro- fessional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical sup- plies, x-ray or medical information for you.

***Disaster Relief:***

We may share medical information to one of our affiliated fundraising foundations to contact you for fundraising Purposes. We will limit our use and sharing to information that decribes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

***Research in Limited Circumstances:***

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

***Funeral Director, Coroner, Medical Examiner***

To help them carry out their duties, we may share med-

ical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

***Specialized Government Functions:***

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and other, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

***Court Orders and Judicial and Administrative Proceedings:***

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

***Public Health Activities:***

As required by law, we may disclose your medical information to a public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposed of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

***Victims of Abuse, Neglect, or Domestic Violence:***

We may use and disclose medical information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being a part of a crime or has escaped from legal custody.

***Workers Compensation:***

We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

***Health Oversight Activities:***

We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

***Law Enforcement:***

Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

***Appointment Reminders:***

We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

***Alternative and Additional Medical Services:***

We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

## 4. Your Individual Rights

**You Have the Right to:**

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for cetain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changed in any future sharing of that information.
6. If you wish to receive a paper copy of thie privacy notice then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

## Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Office and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

*These privacy practices are currently in effect and will remain in effect until further notice.