

Mina Modaresi, D.D.S., P.C.

**Regal Dental Care
45985 Regal Plaza, Suite 160
Sterling, VA 20165
(703) 433-1122**

NAME _____

Family Members #1 _____

#2 _____

#3 _____

#4 _____

Address: _____

Telephone: Home: () - -

Work: () - -

Cell: () - -

E-mail _____

Allergies: _____

Heart Murmur or Mitro Valve Prolapse: _____

Pre-Med: _____

Prosthetic Joints: _____

Other: _____

Appointment Date and Time: _____

How did you hear about us? _____

Ins. Info:

Subscribers Name: _____ **SS#:** _____

Carrier: _____ **Phone#:** _____ **DOB:** _____

Patient Information

Patient Name: _____ Date: _____
Last First MI
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): (_____) _____ (Work): _____ Ext: _____ Best time to call: _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
Address: _____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Fainting	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Growths	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hay Fever	Due date: _____	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Respiratory Problems	Latex allergies
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Need for premed
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatism	prior to dental appt.
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problems	Other: _____
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Stomach Problems	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis	
	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Tumors	

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

LIST OF MEDICATIONS

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: _____

Page 1

Mina Modaresi, DDS, P.C.
45985-160 Regal Plaza
Sterling, VA 20165

Patient Name:

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 carefully

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical record only for each of the following purposes: treatment, payment, and health care operations.

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **HEALTHCARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, post-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 16, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information or contact the US Department of Health and Human Services.

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave S.W.
Washington, D.C. 20201
(202) 619-0257
1-877-686-6778

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: Student _____ occupation: _____
Street _____ City _____ State _____ Zip Code _____

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: Guardian _____

Secondary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street City State Zip Code
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, the dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand that any unpaid balances due to student status or lack of student status are my responsibility.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Regal Dental Care reserves the right to charge a \$30/ half hour fee for broken appointments without a 24 hour notice.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay in advance the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within two (2) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any claim or condition hereunder shall not constitute a waiver of any former term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Mina Modaresi, DDS, P.C.

45985-160 Regal Plaza

Sterling, VA 20165

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, via phone, mail or e-mail.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please specify) _____