Mehdi Zamani, D.D.S.

120 Sister Pierre Drive, suite 503
Towson, MD 21204
(410) 825-7500

Patient Name: _____ Date: _____
Last First MI

Gender:_____Date of Birth_____ Family Status: ☐ married ☐ single ☐ child ☐ other

Social Security #: _____ E:mail: _____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

What phone number can we reach you at in case of an emergency: _____

Address: _____
Street Apartment

_____
City State Zip Code

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:_____

Responsible Party Information

Please only fill this out someone other than you is responsible for payment

Name: _____ Relationship: _____
Last First MI

Social Security #: _____ Date of Birth_____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Address: _____
Street Apartment

_____
City State Zip Code

Employment Information

Employer Name:_____

Address: _____
Street

_____
City State Zip Code

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 & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law 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 prepared this explanation of how we are required to maintain privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or maintaining health care and related services by one or more health care providers. For example, we may need to share information with another provider or specialist involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization reports. For example, we disclose treatment information when billing a dental plan for dental services.
- Health care operations include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

Unless you require otherwise, we may use or disclose health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment from your healthcare plan. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or at work. 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 certain rights in regards to your protected health information, which you can exercise by presenting a written request to our office listed below:

- 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 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 written to remove it.
- The right to request to receive confidential communications of protected health information from us or by alternative means or at alternative locations
- The right to access, inspect and copy your protected health information
- The right to request an amendment to your protected health information
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice 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 August 24, 2007 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 make new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the revised notice from this office.

You have the right to file a formal written complaint with us at the address listed below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Advanced Dental Care
120 Sister Pierre Drive
suite 503
Towson, MD 21204

For more information or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, SW
Washington, DC 20201
(877) 696-6775

_____ _____

Signature Date

Insurance Information

□ No insurance, self pay
If so, what method of payment will you be using today? □ credit card ☐□ check □ cash

Name of Insured:_____ Is insured a patient? □ Yes □ No
Last First

Insured's Birth Date: _____ ID #:_____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other _____

Insurance Plan Name and Address: _____

_____

I hereby consent to the taking of x-rays, photographs and other necessary records before, during and after treatment and to the use of the same by this practice for scientific papers and demonstrations

I also authorize the release of my insurance company or companies and information including the diagnostic records and diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for treatment provided.

_____ _____
signature date

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, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I authorize the release to my insurance company any information including the diagnostic records and diagnostic of any treatment required to comply with applicable law and facilitate the billing and reimbursement for treatment provided.

A service charge of 1½% 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. Any and all payments made by check that are denied due to non-sufficient funds and all delinquent accounts that are sent to collections will incur a minimum $25 charge on the patients account and, if left unresolved, can incur a charge up to the original balance. I understand that this office may charge a fee of $50 for any cancellations of appointment made 24 or less hours prior to treatment or any failures to show for a scheduled appointment.

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 therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) 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 breach of any time or condition hereunder shall not constitute a waiver of any further 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.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Medical Information

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

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

- ☐ AIDS or HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Canidiasis (thrush)
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Lupus Erthematosus
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Prosthetic Joint
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other Allergies:

_____

_____

Are you currently taking birth control pills? ☐ Yes ☐ No
Please list any medication you are currently taking:

_____

_____

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: _____

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.

_____ Date: _____

Signature of patient, parent or guardian

General Consent for Treatment

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

Drug Reactions and side effects
Damage to adjacent teeth of fillings
Post-operative infection
Post-operative bleeding that might require additional treatment
Delayed healing of an extraction site, (dry socket) necessitating additional care
Sinus involvement during removal of upper molars which may require additional treatment or surgical repair at a later date
Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue or other areas
Bruising, swelling, sensitivity or pain
Failure of the dental procedure necessitating additional treatment
Breakage of dental instruments inside tooth canals making additional treatment necessary
Complications during treatment necessitating referral to a specialist

I understand the recommended treatment for my conditions, the risk of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fee(s) have involved have also been explained. All of my questions have been answered and I have not been offered any guarantees.

_____ Date: _____

Signature of patient, parent or guardian