PATIENT INFORMATION:

How Did You Hear About Our Office?

Patient's Name (LAST / FIRST / MIDDLE) | Sex M F | Marital Status | Date of Birth

Address | City | State | Zip

Home Phone | Other Phone | Soc. Sec. # | Email Address

Employer Or If Patient Is Child Parent | Work Address | Zip | Occupation/ School

Person Responsible For Account or Policy Holder: (LAST / FIRST) | Relationship to Patient | Date of Birth:

Address | City | State | Zip

Phone | Soc. Sec. # | Occupation | Work Phone #

Employer | Work Address | Zip

Who Is Patient's Physician? | Physician Phone | Last Exam

MEDICAL HISTORY:

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? - INDICATE WITH A (√)

What is your: Height _____ Weight _____

- ☐ Major Operations
- ☐ Drug Allergies (Penicillin, or Aspirin, etc.)
- ☐ Other Allergies
- ☐ Cancer Treatment
- ☐ Pregnant Now
- ☐ Sinus Trouble
- ☐ Kidney Trouble
- ☐ Fainting
- ☐ Recipient of Donor Organ,
- ☐ Heart Valve, Joint, Pacemaker
- ☐ Bleeding Disease/Anemia
- ☐ Heart Ailment
- ☐ High/Low Blood Pressure
- ☐ Diabetes
- ☐ Blood Transfusions Received
- ☐ Respiratory Disease/Asthma
- ☐ Rheumatic Fever
- ☐ Arthritis/Rheumatism
- ☐ Tumor/Growth
- ☐ Liver Disease/Hepatitis
- ☐ Stomach/Intestine Disease
- ☐ Venereal Disease
- ☐ Psychiatric Care
- ☐ Epilepsy/Seizures
- ☐ Thyroid
- ☐ Tuberculosis (T.B.)
- ☐ Stroke
- ☐ Eye Disorder
- ☐ HIV

Describe Any Current Medical Treatment, Including Drugs Taken, Even Though Not Listed Above:

DENTAL HISTORY:

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? - INDICATE WITH A (√)

- ☐ Do You Like Your Smile? _____
- ☐ Cigarettes, Pipe or Cigar Smoking
- ☐ Bleeding Gums. How Long_____
- ☐ Food Impaction
- ☐ Clenching or Grinding
- ☐ Burning of Tongue
- ☐ Swelling or Lumps in Mouth
- ☐ Frequent Blisters on Lips or Mouth
- ☐ Pain Around Ear
- ☐ Unusual Sounds in Ear While Eating
- ☐ Do You Want to Save Your Teeth?_____
- ☐ Teeth Sensitive to Cold, Heat, Sweets, or Pressure
- ☐ Bad Breath
- ☐ Unpleasant Taste
- ☐ Unfavorable Dental Experience
- ☐ Complications from Extractions
- ☐ Periodontal Gum Treatment
- ☐ Orthodontic Treatment (Braces)
- ☐ Mouth Breathing
- ☐ Oral Habits, i.e., Fingernail Biting Cheek Biting, etc.
- ☐ Texture of Toothbrush_____
- ☐ Frequency of Brushing _____
- ☐ Dental Floss
- ☐ Inter Dental Stimulation/Proxy Brushes
- ☐ Water Jet Device
- ☐ Disclosing Tablets or Solution
- ☐ Fluoride Supplements
- ☐ Dentures/Partials/Bridges

Date Put in: Where:

When Was Your: Last Dental Exam? | Last Full Mouth (Whole Head) X-Rays? | Last Cleaning? | Where?

How Do You Plan To Pay For Your Treatment? Circle One: Cash, Credit Card, Dental Insurance

CERTIFICATION: I certify that the above questions are answered to the best of my knowledge.

CONSENT: I hereby give my consent for treatment deemed necessary by the doctor for myself or my child if a minor.

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 48 hours. This fee covers only a portion of the overhead such a salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you. A minimum charge will be at least $75.00 per person per appointment. I am the responsible person (signed below) for myself, spouse, child, or relative (patient).

INSURANCE: Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of claims. If your claim is not paid, please deal with your insurance agent directly for an explanation. To avoid misunderstandings, we wish our patients to know that all professional services rendered are charged directly to the patient. I agree that any balances not paid may be automatically and fully charged to me through my credit card or cards.

RESPONSIBILITY: I agree that fees are due in full upon completion of designated treatment, and if not fully paid, the balances shall carry a finance charge of 2% per month (24% A.P.R.)in addition to any collection fees incurred. I agree that any amount due is a debt and that below signed agrees to pay attorney's fees and court costs.

Signature_____ Date_____

(PATIENT, PARENT OR GUARDIAN, IF PATIENT IS A MINOR, RESPONSIBLE PARTY)

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY POLICIES/ AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

This form will authorize Fort Thomas Family Dentistry, P.S.C. to disclose any/all personal health information (PHI) for the use of treatment, payment activities, and healthcare procedures.

Practice Name: Fort Thomas Family Dentistry, P.S.C.
Doctor's Name: Masoud Hekmatyar
Address: 40 N. Grand Ave Suite 202 Fort Thomas, KY 41075

PATIENT'S CONSENT

Name: _____

Address: _____

City: _____State_____Zip_____

Telephone: ( ) _____

Emergency Contact: _____

Emergency Contact Telephone(s): _____

I have read the Notice of Privacy Policies and I consent to the use of my PHI for the purpose of healthcare procedures, payment activities, and treatment.

Signature_____ Date_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

FORT THOMAS FAMILY DENTISTRY, P.S.C.
Notice of Privacy Practices

This notice describes how medical and/or dental information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.
The privacy of your health information is important to us.

Managing the privacy of your protected health information (PHI) is very important to Fort Thomas Family Dentistry, PSC/ Masoud Hekmatyar, D.M.D. We maintain protocols to ensure the security and confidentiality of your personal information. The information below illustrates the manner your protected health information could be accessed and released and what you need to know about this process.

Fort Thomas Family Dentistry, PSC/Masoud Hekmatyar D.M.D. Responsibilities: We are mandated by federal and state law to maintain the privacy of your protected health information. As part of their regulations we are required to give you this notice about our privacy practices, our legal duties, and your rights to your PHI. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice becomes effective 4/1/2003.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the modifications effective for all protected health information we maintain, including protected health information we created or received before the changes were made.

HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: Your PHI may be used and disclosed to obtain payment for services we provided.
Healthcare Processes: We may use and disclose your PHI in connection with our healthcare process. These processes include quality assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those in this notice.

Your PHI may be used and disclosed to you as described in the patient rights section of this notice. In addition, your PHI may be used and disclosed to a family member or other person to the extent necessary to assist you with your healthcare, with your authorization.

Person Involved in Care: Your PHI may be used or disclosed to your personal representative in order to inform he/she of your location, your general condition, or death. If you are present and wish to object to such disclosures of your health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose PHI only that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and experience with common practices to make reasonable inferences in allowing your representative to pick up filled prescriptions, medical supplies, X-rays, etc.

Marketing Health-Related Services: The use of your PHI for the purpose of marketing communication is prohibited without your written authorization.

Required by Law: Your PHI may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your PHI may be disclosed to the appropriate authorities. If we have reason to believe the disclosure of your PHI will prevent a serious threat to your health or safety, or the health or safety of others, we may have to provide the necessary health information.

National Security: Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information. Under some circumstances the military may require disclosure of health care information for armed forces personnel.

Appointment Reminders: We may use or disclose your health care information to provide you with appointment reminders in the forms of voicemail, postcards, email, or letters.

PATIENT RIGHTS

Right to Inspect and Copy: At all time you have the right to review your PHI, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so we will accommodate your request. Fort Thomas Family Dentistry, PSC will require that a staff member be present when PHI is being inspected by a patient. Your request to obtain your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice.

Right to Amend: If you believe that healthcare information about you is incorrect or incomplete, you may ask us to amend the information. The amendment must be a written which should include an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Right to Disclose Accounting: You have a right by written request to receive a list of disclosures we made of medical information about you for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not prior to April 14, 2003. We may charge you for the cost of providing the list.

Restrictions: You have the right to request in writing that we place additional restrictions on our use and disclosure of your health information. All reasonable requests will be considered, but we are not required to agree to all requests. We will follow agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how your are communicated to regarding your PHI. Your request must be in writing and can spell out other ways or other locations regarding your PHI communication. You must identify agreed upon explanations of payment arrangements under alternative communication.

You have a right to a paper copy of this notice.

QUESTIONS AND COMPLAINTS

If you are concerned we may have violated your privacy rights, or you disagree with a decision we made about access to the health information, you may complain to us using the contact information listed below. You may also submit a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint to the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains very important. Fort Thomas Family Dentistry PSC, will not retaliate against any patient who chooses to lodge a complaint regarding privacy practices and/or the use, disclosure, and handling of protected health information. We are committed to ensure your privacy.

Contact Person's Name: Masoud Hekmatyar, D.M.D.
Telephone: (859) 581-7678 Fax: (859) 581-2624
Address: 40 N. Grand Ave, Suite 202 Fort Thomas, KY 41075