Modern Dentistry

Amir Mojaver, D.M.D.

...Leading Edge Dentistry for the Quality Minded Individual.

PATIENT INFORMATION

Patient Name _____ _____
Last First MI Preferred Name

SS# _____ Date of Birth _____/_____/_____ Drivers License # _____

Home Address _____ City _____ Zip _____

Home Phone #_____ Cell Phone # _____ Work Phone # _____

E-mail Address (personal) _____ E-mail Address (work) _____

Do you need a confirmation regarding appointments? □ No □ Yes (we confirm and appreciate reschedules 2 business days prior to appointment)

If Yes, preferred way of contacting you regarding appointments: □ Home □ Cell □ Work □ Personal E-mail □ Work E-mail □ Other

Marital Status: □ Minor □ Single □ Married □ Separated □ Divorced □ Widowed

If Married, spouse's name _____

If Minor, name of mother and father _____

If Student, Name of School / College _____City _____ State _____

Student Status: □ Full Time □ Part Time

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Person Responsible for Payment of Account _____ Relation to Patient □ Self □ Spouse □ Parent □ Other

SS# _____ Date of Birth _____/_____/_____ Drivers License #_____

Residence/Address _____ City _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Information

Name of Insurance Company _____ Insurance Provided by Employer □ Yes □ No

Subscriber _____ Relationship to Subscriber □ Self □ Spouse □ Child □ Other

Insured SS # _____ Insured Date of Birth _____/_____/_____

Name of Employer _____

Business Address _____ City _____ Zip _____

Secondary Dental Insurance Information (if any)

Name of Insurance Company _____ Insurance Provided by Employer □ Yes □ No

Subscriber _____ Relationship to Subscriber □ Self □ Spouse □ Child □ Other

Insured SS # _____ Insured Date of Birth _____/_____/_____

Name of Employer _____

Business Address _____ City _____ Zip _____

REFERRAL SOURCE – who can we thank

Name of our patient who referred you? _____ How do you know this person? _____

If not referred, how did you hear about our office? _____

YOUR FAVORITES

Favorite TV Channels (Satellite TV in the rooms)_____

Favorite Type of Music (Music in the rooms)_____

Favorite Things to Do _____

(CONTINUED ON OTHER SIDE) →

PATIENT MEDICAL HISTORY

Patient Name _____ Date of Birth _____/_____/_____

PHYSICIAN'S Name _____ Phone _____ Date of Last Exam _____/_____/_____

	Yes	No	
Are you under a physician's care now?	☐	☐	If yes, explain _____
Have you been hospitalized or had a major operation?	☐	☐	If yes, explain _____
Are you taking medications, including non-prescription?	☐	☐	If yes, explain _____
Do you, or have you taken Fen-Phen or Redux?	☐	☐	If yes, explain _____
Are you on a special diet?	☐	☐	If yes, explain _____
Do you use tobacco?	☐	☐	
Do you use controlled substances?	☐	☐	

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV positive	☐	☐	Epilepsy or Seizures	☐	☐	Low Blood Pressure
☐	☐	Alzheimer's Disease	☐	☐	Excessive Thirst	☐	☐	Lung Disease
☐	☐	Anemia	☐	☐	Fainting Spells/Dizziness	☐	☐	Mitral Valve Prolapse
☐	☐	Angina, Chest Pains	☐	☐	Frequent Headaches	☐	☐	Parathyroid Disease
☐	☐	Arthritis/Gout	☐	☐	Glaucoma	☐	☐	Psychiatric Care
☐	☐	Artificial Heart Valve	☐	☐	Hay Fever	☐	☐	Radiation Treatments
☐	☐	Artificial Joint	☐	☐	Heart Attack/Failure	☐	☐	Recent Weight Loss
☐	☐	Asthma	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever
☐	☐	Blood Disease	☐	☐	Heart Pace Maker	☐	☐	Rheumatism
☐	☐	Blood Transfusion	☐	☐	Heart Trouble/Disease	☐	☐	Scarlet Fever
☐	☐	Breathing Problem	☐	☐	Hemophilia	☐	☐	Sexually Transmitted Disease
☐	☐	Bruise Easily	☐	☐	Hepatitis A	☐	☐	Shingles
☐	☐	Cancer	☐	☐	Hepatitis B or C	☐	☐	Sickle Cell Disease
☐	☐	Chemotherapy	☐	☐	Herpes	☐	☐	Stomach/Intestinal Disease
☐	☐	Congenital Heart Disorder	☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Convulsions	☐	☐	Hives or Rash	☐	☐	Swelling of Limbs
☐	☐	Diabetes	☐	☐	Hypoglycemia	☐	☐	Thyroid Disease
☐	☐	Drug Addiction	☐	☐	Irregular Heartbeat	☐	☐	Tuberculosis
☐	☐	Excessive Bleeding	☐	☐	Kidney Problems	☐	☐	Tumors or Growths
☐	☐	Easily Winded	☐	☐	Leukemia	☐	☐	Ulcers
☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐	Yellow Jaundice

Have you ever had any serious illness not listed above? (describe) _____

WOMEN ONLY

Yes	No		
☐	☐	Are you pregnant or possibly pregnant	Due Date _____
☐	☐	Are you nursing	
☐	☐	Are you taking oral contraceptives	

(CONTINUED ON OTHER SIDE) →

ALLERGIES

DO YOU HAVE ANY OF THE FOLLOWING ALLERGIES?

Yes	No		Yes	No	
☐	☐	Penicillin, any antibiotic	☐	☐	Local anesthetics (novocaine, lidocaine, etc.)
☐	☐	Sulfa Drugs	☐	☐	Aspirin, codeine, or other pain medication
☐	☐	Iodine	☐	☐	Hives, contact dermatitis, latex sensitivity
☐	☐	Any Metals (nickel, mercury, etc.)	☐	☐	Allergic to any other medication

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PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____/_____/_____

How nervous does dental treatment make you?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Extremely

PLEASE ANSWER THE FOLLOWING:

Yes	No		Yes	No		Yes	No	
☐	☐	Gums bleed while brushing or flossing	☐	☐	Problems in your jaw	☐	☐	Dry mouth
☐	☐	Burning sensation on tongue		☐	Clicking, popping, or grinding	☐	☐	Mouth breathing
☐	☐	Tooth or mouth pain recently		☐	Pain	☐	☐	Sensitivity to cold
☐	☐	Have any sores / lumps in or near your mouth		☐	Difficulty opening or closing	☐	☐	Sensitivity to hot
☐	☐	Any mouth, head, neck or jaw injuries		☐	Difficulty in chewing	☐	☐	Sensitivity to sweets
☐	☐	Do you clench or grind your teeth	☐	☐	Ever worn partials / dentures	☐	☐	Sensitivity when biting
☐	☐	Unpleasant taste / bad breath	☐	☐	Orthodontic treatment / braces	Brush per day? _____		
☐	☐	Periodontal / gum surgery or disease	☐	☐	Oral surgery	Floss per day? _____		

☐ ☐ Any unpleasant dental experience? If yes, describe_____

☐ ☐ Any complications with / reaction to dental treatment? If yes, describe_____

☐ ☐ Do you have any dental concerns? If yes, describe _____

What do you **like** about your teeth? _____

What do you **dislike** about your teeth? _____

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 or dental status.

_____ _____ _____/_____/_____

Signature of Patient, Parent or Guardian Relationship to Patient Date

_____ _____/_____/_____

Doctor's Signature Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the dentist to release to hospital or health care service plans, or insurance companies, any and all information and records including x-rays about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

INITIALS _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

INITIALS _____

DENTAL MATERIALS FACTS

I have received a copy of the Dental Materials Fact Sheet as required by law.

INITIALS _____

SUBMISSION OF CLAIMS AND FINANCIAL RESPONSIBILITY

I authorize the office of Modern Dentistry to submit claims for payment for services to my insurance companies or health care service plan on my behalf and in my name. I authorize and request the insurance company to pay directly to the dentist. I am responsible for knowing my benefit coverage. I understand that services cannot be rendered on the assumption that charges will be paid by the insurance company. I understand that the insurance is an agreement between me and my insurance company. It is my responsibility to pay any deductibles, co-payments, or any other balance not paid by my insurance company. Modern Dentistry requires my estimated portion at the time treatment is rendered.

I understand that Modern Dentistry will make every effort possible to assist me with my insurance coverage. Modern Dentistry allows no more than 90-days for the insurance to submit payment. Any outstanding claims past the 90-day mark will be my responsibility. If the insurance submits a payment following the deadline, Modern Dentistry will reimburse me or credit my account. I understand that my dental insurance carrier may pay less than the estimate I was given and I understand that I am financially responsible for any charges not covered by my insurance benefits. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

INITIALS _____

CANCELLATION / MISSED APPOINTMENTS

I understand that should I need to cancel an appointment time reserved specifically for me, **I will notify Modern Dentistry 48 hours / 2 business days in advance** so that my time may be utilized by another patient. If I fail to give a minimum for 48 hours / 2 business days notice, I will be required to pay a fee of $50 before a new appointment will be made for me.

INITIALS _____

AUTHORIZATION FOR USE OF IMAGES

I understand that Dr. Amir Mojaver may take video or still images of the work that he is doing. I consent to my dentist, or a representative of his staff, taking these images. I understand that these images may be used for the purpose of education, publicity, promotion, and advertising. I understand that I will receive no compensation for such use.

INITIALS _____

INFORMED CONSENT

1. **Examination and X-rays**: I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.
2. **Changes in Treatment Plan**: I understand the recommended treatment and I am financially responsible. I understand I am no way obligated to any treatment. I also acknowledge that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission Dr. Mojaver to make any/all changes and additions necessary.
3. **Drugs and Medication**: I understand that antibiotics, analgesics and other medications can cause allergic reactions, such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that occasionally, upon injection of local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation in the area of injection.
4. **Temporomandibular Joint Dysfunction (TMD)**: I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

INITIALS _____

Name of Patient _____ Date _____/_____/_____

Signature of Parent or Guardian _____ Relationship to Patient _____

NOTICE OF PRIVACY PRACTICES

Modern Dentistry
Amir Mojaver, D.M.D. PC
4765 Carmel Mountain Road, Ste 208
San Diego, CA 92130
(858) 259-4765
Effective date of notice: 01/01/2006

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and the rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we

will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.