FREDERICK FAMILY DENTISTRY

NEW PATIENT INFORMATION

(Please Print Clearly)

Date: _____

Patient Information

Last Name	**First Name**	**MI**	**Patient's Social Security Number**
Address (Street)			**Date of Birth**
City	**State**	**Zip**	**Home Phone**
Cell Phone	**Work Phone (Ext)**		**E-mail**
Emergency Contact			**Emergency Phone**
Preferred Contact Method: □ Home Phone □ Cell Phone □ E-Mail	**Referred From**		**Phone**
Sex □ Male □ Female	**Height**	**Weight**	
Check appropriate Box: □ Minor □ Single □ Married □ Divorced □Widowed □ Separated			
If you are completing this form for another person, what is your relationship to that person?	**Name**		**Relationship**

Insurance Information

Primary Insurance Company	**Group No.**	**Policy ID No.**
Policy Holder's Name	**Date of Birth**	**Relationship to patient**
Policy Holder's Employer		**Policy Holder's Social Security Number**

Guarantor Information (For Minors)

Guarantor's Name			**Social Security Number**
Address (Street)			**Home Phone**
City	**State**	**ZIP**	**Work Phone**

Patient's Authorization

I authorize BABAK GANJAVIAN, DDS to apply for benefits on my behalf for services rendered by BABAK GANJAVIAN, DDS. I request payment from my insurance company be made directly to BABAK GANJAVIAN, DDS. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information for this visit or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of my primary responsibility and obligation to pay for services provided, when a statement is rendered.

Patient (or Minor Patient's Representative) Signature	**Date**

Patient Medical History

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

Name of Your Physician _____ Physician's Phone No. _____
Date of last physical examination _____

1. Are you under a physician's care now?	○Yes	○ No	Why? _____
2. Have you ever been hospitalized or had a major operation?	○Yes	○ No	Describe _____
3. Have you ever had a serious head or neck injury?	○Yes	○ No	Discuss _____
4. Are you taking any medication, pills, or drugs?	○Yes	○ No	What? _____
5. Do you take, or have you taken biophosphonates (**Fosomax, Zometa, Didronel, Reclast, Bonvia, Actonel, Aclasta, Aredia, Atelvia, Skelid**)?	○Yes	○ No	_____
6. Do you take anticoagulates **(Warfarin, Coumadin, Jantoven, Heparin, Plavix, Argatroban Eliaquis, Xarelto, Pradaxa, Lovenox, Arixtra, Fragmin Angiomax, Refludan, Danaparoid, Dabigatran?)**	○Yes	○ No	
7. Do you have artificial joints (hip or knee replacements)?	○Yes	○ No	
8. Do you use tobacco?	○Yes	○ No	
9. Do you use controlled substances?	○Yes	○ No	

Women: Are you
- □ Pregnant
- □ Nursing
- □ Taking oral contraceptives

Are you allergic to, or have you had any reactions to the following?

□ Aspirin □ Penicillin or other antibiotics □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics

□ Sulfa □ Barbiturates or Sedatives □ Iodine □ Other _____

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

□ AIDS/HIV Positive	□ Cold Sores/Fever Blisters	□ Genital Herpes	□ Kidney Problems	□ Shingles
□ Alzheimer's Disease	□ Congenital Heart Disease	□ Glaucoma	□ Leukemia	□ Sickle Cell Disease
□ Anaphylaxis	□ Stomach/Intestinal Disease	□ Hay Fever	□ Liver Disease	□ Sinus Trouble
□ Anemia	□ Cortisone Medicine	□ Heart Attack/Failure	□ Low Blood Pressure	□ Spinal Bifida
□ Angina	□ Diabetes Type: _____	□ Heart Murmur	□ Lung Disease	□ Stroke
□ Arthritis/Gout	□ Drug Addiction	□ Heart Pacemaker	□ Mitral Valve Prolapse	□ Swelling of Limbs
□ Artificial Heart Valve	□ Easily Winded	□ Heart Trouble/Disease	□ Pain in Jaw Joints	□ Thyroid Disease
□ Artificial Joint	□ Emphysema	□ Hemophilia	□ Parathyroid Disease	□ Tonsillitis
□ Asthma	□ Epilepsy or Seizures	□ Hepatitis A	□ Psychiatric Care	□ Tuberculosis
□ Blood Disease	□ Excessive Bleeding	□ Hepatitis B or C	□ Radiation Treatment	□ Tumors or Growths
□ Blood Transfusion	□ Excessive Thirst	□ Herpes	□ Recent Weight Loss	□ Ulcers
□ Breathing Problem	□ Fainting Spells/Dizziness	□ High Blood Pressure	□ Renal Dialysis	□ Venereal Disease
□ Bruise Easily	□ Frequent Cough	□ Hive or Rash	□ Rheumatic Fever	□ Yellow Jaundice
□ Cancer/Chemotherapy	□ Frequent Diarrhea	□ Hypoglycemia	□ Rheumatism	□ Convulsions
□ Chest Pains	□ Frequent Headaches	□ Irregular Heartbeat	□ Scarlet Fever	

Have you ever had any serious illness not listed above? □ Yes □ No If yes, please explain _____

_____

To the best of my knowledge, the questions in 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 of Patient or Guardian Date

_____ _____
Signature of Dentist Date

Frederick Family Dentistry – Financial Policy

This Notice describes your financial obligation and payment options.

Payment is due at the time services are rendered. For your convenience we accept Cash, Care Credit, CitiHealth, Visa and Master Card. Please note,

WE DO NOT ACCEPT CHECKS.

Dental Insurance: Insurance benefits are determined by your employer and your insurance carrier, not your dentist. You are responsible to know the scope of your insurance policy and its limitations. Insurance is not a guarantee of payment; insurance companies typically will not pay for all your treatments. If you receive a statement from our office and disagree with how your insurance carrier processed the claim, please call the carrier. Any deductible or estimated co-payment amount will be due at the time of treatment. Your insurance policy is a contract between you and your insurer. Your account with us and payments are your responsibility, not your insurance company's. As a courtesy we will be glad to submit your insurance claim on your behalf. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment. If payment for services already rendered has not been paid in full within 90 days, either by you or your insurance company, the remaining balance is considered due and collectible before any further treatment is rendered.

☆ Initial Here:_____

Delinquency: We reserve the right to charge and collect a fee of $50.00 for broken appointments - appointments that are canceled or broken without 48-hours advance notice, or appointments that the patient has arrived 15 or more minutes late to. . Exceptions will be made on a case by case basis. Appointments are reserved exclusively for you. If three appointments are missed by you and/or your family member(s) that were not properly notified, you may be dismissed from our practice. Any account balance overdue longer than 90 days is considered delinquent and may be sent to small claims court or a collections agency with proper notice given to you in advance. You are responsible for any legal or collections related fees. Payment in full of any past due balance is expected before any further treatment is rendered.

X-Rays: We reserve the right to charge a $20.00 fee for duplication of x-rays.

Discounts & Down Payment: We will fill out your dental insurance claim form for you and will receive payment directly from your insurance company usually in 4-6 weeks. This is our way of saying thank you for being financially responsible and reducing our load of paper work, administrative, and accounting expenses.

Payment Plans: We offer extended payment options through Care Credit, which allows for up to 6 months at no interest and no finance charges for services totaling $200.00 or more, and revolving credit for services under $200.00. Care Credit is offered by GE Financial and is subject to a credit review by them.

As guarantor of my account, I understand that I am solely responsible for all of the fees for the dental treatment. I further agree that I have received a copy of this office financial policy and agree to its contents.

Print your Name: _____ Patient's Name if not self: _____

Signature:_____ Date:_____

FREDERICK FAMLIY DENTISTRY

Notice of Privacy Practices

This Notice describes how health 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 here at Frederick Family Dentistry.

Our legal duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect on June 1, 2008, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Practice Administrator of this office.

Uses and Disclosures of health information: We use and disclose health information about you for treatment, payment and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Health care Operations: We may use or disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. However nothing in this section requires Frederick Family Dentistry to oversee, supervise or dictate the professional activities of duly licensed dental professionals.

Telephone conversations: May be monitored for quality assurance and employee training.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures 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 described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence. counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, e-mail, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. (You must make a request in writing to obtain access to your health care information. We may charge you a reasonable cost-based fee for expenses such as copies, postage and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explaining why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also 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 with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Heath and Human Services.

Patient Signature:_____ Date:_____