ACQUAINTANCE FORM

FOR YOUR WELFARE AND OUR EFFICIENCY OF DIAGNOSIS AND TREATMENT
PLEASE FILL IN THE FOLLOWING CONFIDENTIAL FORM COMPLETELY. **PLEASE PRINT CLEARLY.**

PATIENT INFORMATION **(To be completed by the patient – please PRINT in ink)**

Date _____/_____/_____

Mr. / Mrs. / Ms. / Dr.

Patient Name _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____

SSN# _____ Driver License# _____

Sex ☐ M ☐ F Age _____ Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext. _____ Cel Phone (_____) _____

E-mail._____

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Whom may we thank for referring you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Restorative Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath	☐ Yes	☐ No
Bleeding Gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Gag Reflex	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity to biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often to you floss? _____

How often do you brush? _____

_____ _____
Signature of patient (or Parent or Guardian if patient is under 18) Date

Medical History Questionnaire

Patient Name: _____ Date of Birth _____

Please answer all questions **by checking a box under Yes or No**. (Please do not draw a line). Your responses will be held strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concern to a member of our team.

Do you have, or did you ever have, any of the following?

Cardiovascular:

YES	NO	
☐	☐	High blood pressure
☐	☐	Heart disease from childhood
☐	☐	Heart murmur
☐	☐	Mitral valve prolapse
☐	☐	Rheumatic fever
☐	☐	Use of Phen-Fen
☐	☐	Pacemaker
☐	☐	Vascular graft
☐	☐	Heart valve replacement
☐	☐	Heart attack
☐	☐	Heart Surgery
☐	☐	Congestive heart failure
☐	☐	Angina (chest pain)
☐	☐	Irregular heart beat
☐	☐	Stroke
☐	☐	Increased cholesterol

Endocrine/Hematologic/ Oncologic/Immune:

YES	NO	
☐	☐	Hypoglycemia (low blood sugar)
☐	☐	Diabetes
☐	☐	Thyroid disease
☐	☐	Hemophilia
☐	☐	Sickle cell disease
☐	☐	Bleeding tendency
☐	☐	Anemia
☐	☐	Cancer
☐	☐	Radiation therapy
☐	☐	Chemotherapy
☐	☐	Tumor growth on head or neck
☐	☐	HIV infection/AIDS
☐	☐	Organ transplant
☐	☐	Blood transfusion
☐	☐	Herpes

Social:

YES	NO	
☐	☐	Do you use tobacco products? If so, how much? _____
☐	☐	Do you drink alcohol?
☐	☐	Every day? If so, how much? _____
☐	☐	Do you use recreational drugs?

Do you have, or did you ever have, any of the following?

Musculo-Skeletal/CNS/Developmental:

YES	NO	
☐	☐	Chronic jaw and facial pain
☐	☐	Chronic headache pain/migranes
☐	☐	Chronic neck/back pain
☐	☐	Neuralgia
☐	☐	Joint replacement
☐	☐	Facial implants
☐	☐	Osteoarthritis
☐	☐	Rheumatoid arthritis
☐	☐	Spinal cord injury
☐	☐	Seizures
☐	☐	Fibromyalgia
☐	☐	Dizziness
☐	☐	Multiple Sclerosis
☐	☐	Parkinson's
☐	☐	Cognitive Impairment
☐	☐	Dementia / Alzheimer's
☐	☐	Fainting spells
☐	☐	Visual impairment
☐	☐	Glaucoma
☐	☐	Hearing impairment

Gastro-Intestinal/Genito-Urinary:

YES	NO	
☐	☐	Acid reflux/GERD
☐	☐	Hepatitis (A, B, C or other?)
☐	☐	Kidney dialysis
☐	☐	Ulcers
☐	☐	Sexually transmitted disease
☐	☐	Denied permission to give blood

Psychological:

YES	NO	
☐	☐	Bulimia/Anorexia
☐	☐	Anxiety / Nervousness
☐	☐	Depression
☐	☐	Mental health treatment
☐	☐	Insomnia
☐	☐	Chemical dependancy
☐	☐	Bipolar Disorder

Medical History Questionnaire (continued)

Patient Name: _____

Do you have, or did you ever have, Any of the following?

Respiratory

YES	NO	
☐	☐	Asthma
☐	☐	Chronic sinus problems
☐	☐	Night sweats
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Cough, persistant or bloody
☐	☐	Shortness of breath

Other: _____

Medication Allergy or Intolerance:

YES	NO	
☐	☐	Penicillin
☐	☐	Dental anesthetic ("Novocaine")
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Latex products
☐	☐	Iodine
☐	☐	Sulfa

Other: _____

_____

Do you have any medical conditions not already mentioned?

_____

_____

History of Hospitalization/Surgical Procedures:

_____

_____

_____

Medications:

YES ☐ NO ☐ Are you taking any prescription medicines, any over-the-counter Items, or any herbal medicines now? If so, please list them and the doses you use:

_____

_____

_____

_____

_____

_____

_____

_____

Do you have or ever had any kind of plastic surgery, implant placement?

☐ Yes (*Please Specify*) ☐ No

_____

_____

_____

FEMALES ONLY:

YES	NO	
☐	☐	Are you pregnant now? If so, #_____months?
☐	☐	Do you take birth control pills?
☐	☐	Are you breast feeding now?

If I have any change in my health status, or any change in my medicines, I will inform my dental health care provider at my next appointment.

_____ _____

Signature of patient (or Parent or Guardian if patient is under 18) Date

Updates (To be filled in at future appointments – please PRINT in ink)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Insurance/ Financial Information **(To be completed by the patient – please PRINT in ink)**

Dental Insurance

Patient's Name _____ DOB _____

Who is responsible for this account? _____

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Name of Insurancy (s)

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent,or Personal Representative

Date _____ Relationship to Patient _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient's Signature: _____ Date: _____

CONSENT:

1. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's needs.
2. I also authorize the doctor to perform all recommended treatments mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor chooses and employ such substance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered unless other arrangement have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 1/2% service charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, a credit bureau report may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form
6. I authorize the use of my Social Security number to file my dental claim.

Patient: _____ Date: _____ Witness: _____

POLICY OF THE OFFICE

So that we may maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees. Once you have made an appointment, remember this time has been reserved for you.

THEREFORE, AT LEAST 24 HOURS NOTIFICATION MUST BE GIVEN IF A CANCELLATION IS ABSOLUTELY NECESSARY, OTHERWISE THE USUAL FEE CHARGE WILL BE MADE.

HIPAA PRIVACY FORM 1

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002

HESSAM NOWZARI. D.D.S. PHD., INC.

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.

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 April 14, 2003 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 us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and 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: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use of disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare 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 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 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 with your healthcare or with payment for your healthcare, 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 or 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 a person's involvement in your healthcare. 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 a 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 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 institution or law enforcement official 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 voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer as alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of our health information for a fee. Contact us using the information listed at the end of this Notice for full explanation of our fee.

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, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month 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 explain 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.

QUESTIONOS 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 or your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by 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 U.S. Department of Health and Human Service.

CONTACT OFFICER: **Claudia Montufar**

TELEPHONE: **(310) 274-0809** **FAX:** **(310) 274-1503**

EMAIL: nowzari.frontoffice@gmail.com

ADDRESS: **120 S. Spalding Drive Suite 201, Beverly Hills, CA 90212**

HESSAM NOWZARI. D.D.S. PHD., INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I _____, have received a copy of this office's notice of privacy practices.

_____

{Please Print Name}

_____

{Signature} {Date}

_____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

_____

_____