PATIENT REGISTRATION

Patient's First Name:_____ Last Name:_____ Middle Name:_____

Preferred Name: _____

Patient Is (please check): Policy Holder _____ Responsible Party_____ Dependent _____

Address:_____

City, State, Zip:_____

Cell Phone: _____ Home Phone: _____Work Phone:_____

Birth Date:_____ Age:_____Sex: _____

Marital Status: Married_____ Single _____ Divorced _____ Separated _____ Widowed _____

Social Security: _____

I would like to receive correspondence via (check all that apply): Email____ Text____Messages____Mail ___

Email Address: _____

How did you hear about our office? _____

Responsible Party (if someone other than patient)

First Name: _____ Last Name:_____ Middle Name: _____

Address:_____

City, State, Zip: _____

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

Birth Date: _____ Social Security: _____

Is another relative of yours a patient at our office?_____

Person to contact in case of an emergency:_____

Closest relative not living with you:_____

Insurance Information

Name of Insured:_____

Relationship of Patient to Insured: Self_____ Spouse_____ Child_____ Other_____

Insured Social Security:_____Insured's Insurance ID #: _____

Insured Birth Date:_____ Employer: _____

Group #:_____

Insurance Company: _____

Insurance Address:_____

City, State, Zip: _____

Insurance Phone Number: _____

I authorize Dr. Brazdo or designated staff member to take x-rays, study models, photographs, and any diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received when due, I understand that a 25% late fee will be added for each month a payment is not received past 60 days.

Patient's Signature: _____ Date: _____

Signature of Parent or Responsible Party: _____

Relationship to Patient: _____

ARTISTIC TOUCH™
DENTISTRY

Maryam Brazdo, DMD

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 taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name: Birth Date: Date Created:

Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No	If yes	
Do you use tobacco?	◯ Yes ◯ No	If yes	
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Women, are you...

◯ Pregnant/Trying to get pregnant? ◯ Nursing? ◯ Taking oral contraceptives?

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic
◯ Metal ◯ Latex ◯ Sulfa Drugs
◯ Local Anesthetics
◯ Other If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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 status.

Signature of Patient, Parent or Guardian:

X Date:

ARTISTIC TOUCH™ DENTISTRY

Maryam Brazdo, DMD

DENTAL HISTORY

Date of Last Dental Visit:_____ Last Dental Cleaning:_____ Last Full Mouth X-rays:_____

What was done at your last dental visit?_____

_____

Previous Dentist's Name:_____

Address:_____

City, State, Zip:_____

Telephone:_____

How often do you have dental examinations?_____

How often do you brush your teeth? How often do you floss?_____

Do you have any dental problems now?_____

If yes, please describe:_____

_____

Are any of your teeth sensitive to:

Hot or cold? **Yes No**
Sweets? **Yes No**
Biting or chewing? **Yes No**
Have you noticed any mouth odors or bad tastes? **Yes No**
Do you frequently get cold sores, blisters or any other oral lesions? **Yes No**

Do your gums bleed or hurt? **Yes No**
Have your parents experienced gum disease or tooth loss? **Yes No**
Have you noticed any loose teeth or change in your bite? **Yes No**
Does food tend to become caught in between your teeth? **Yes No**

Have you ever had:

Orthodontic treatment? **Yes No**
Oral surgery? **Yes No**
Periodontal treatment? **Yes No**
Your teeth ground or the bite adjusted? **Yes No**
A bite plate or mouth guard? **Yes No**
A serious injury to the mouth or head? **Yes No**

If so, please describe, including cause:_____

_____

_____

Do You:

Clench or grind your teeth while awake or asleep? **Yes No**
Bite your lips or cheeks regularly? **Yes No**
Hold foreign objects with your teeth? **Yes No**
(pencils, pipes, pins, nails, fingernails) **Yes No**
Mouth breathe while awake or asleep? **Yes No**
Have tired jaws, especially in the morning? **Yes No**
Smoke/chew tobacco? **Yes No**

Have you experienced:

Clicking or popping of the jaw? **Yes No**
Pain (joint, ear, side of face)? **Yes No**
Difficulty in opening or closing the mouth? **Yes No**
Difficulty in chewing on either side of the mouth? **Yes No**
Headaches, neck aches or shoulder aches? **Yes No**
Sore muscles (neck, shoulders)? **Yes No**

Are you satisfied with your teeth's appearance? **Yes No**

Do you feel nervous about having dental treatment? **Yes No**

If so, what is your biggest concern?_____

Have you ever had an upsetting dental experience? **Yes No**

If yes, please describe_____

FINANCIAL POLICY

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to your treatment.

Self-Pay – Payment is due when services are rendered unless prior arrangements have been made.

Insurance – Deductibles, estimated patient portions, and previous balances are required to be paid at the time of service; unless prior arrangement have been made. While we do our best to check eligibility, maximums, frequencies, and coverage, it is ultimately your responsibility to know and understand your dental insurance. If we are out of network for your insurance, we file claims and wait for payment as a courtesy to you. Our fees are based on what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates. Any balance estimated to come from your insurance that is not paid by your insurance is your responsibility.

Late Fee – When a payment arrangement is in place, or there is balance after the insurance payment, a 25% late fee will be assessed for each month a payment is not received. The late fee will be added once the balance is over 60 days, or the payment arrangement is 60 days past due.

Unique Family Situations – We will be happy to submit to either parent or both parents' insurance, however, it is our office policy that the parent who brings the child in for their appointment is responsible for any co-pays and the balance on the account.

We accept Cash, Check, Visa, Mastercard, Discover, Amex, and Care Credit.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY

Patient/Guardian Signature:_____Date:_____

CANCELLATION, CONFIRMATION, RESCHEDULING AND NO-SHOW POLICY

We know that unexpected unavoidable demands can arise and we certainly understand how such circumstances can interfere with your ability to keep dental appointments. If you find it absolutely necessary to cancel or reschedule an appointment, please be aware we require at least 24 hours' notice so we can use the scheduled time for the benefit of our other patients. If we do not get the 24 hours' notice we will charge $75 cancellation fee to the account.

We do expect a confirmation for all appointments with 24 hours' notice as well. Not confirming an appointment reserves us the right to book over your appointment time.

Patients who do not show up for their appointments without a call to cancel will be considered as a no show. Patients who no show more than two times in a twelve-month period may be dismissed from the practice thus being denied any further appointments with our office.

Our practice firmly believes that good doctor/patient relationship is based upon understanding and good communication. We do our best to remind every patient of their appointments with the doctor including appointment cards, text messages, emails and phone calls. We expect the patient to give us the same courtesy with responding to any of those correspondence with confirmation they will be here for the time we have reserved for them and the doctor.

I,_____, acknowledge that I have been made aware of the cancellation, confirmation, rescheduling and no-show policies for Artistic Touch Dentistry.

Signature:_____Date:_____

Relationship to Patient:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

SECTION B: TO THE PATIENT - PLEASE READ CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have received a copy of our Notice of Privacy Practices with this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information.
We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person at this office. Please understand that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent:
I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

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:_____

If you would like to designate another person (s) to discuss your healthcare, appointments or bills, list and sign below authorizing us to do so:

Name (s):_____

Patient's Signature:_____Date:_____

HIPAA NOTICE OF PRIVATE PRACTICES (1 of 2)

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE READ AND REVIEW CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, dental or mental health condition and related health care services.

L. Uses And Disclosures Of Protected Health Information

Your protected health information may be used and disclosed by your physician, dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the dentist/physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We will also disclose to a family member, spouse, adult children, and information as necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons to the extend necessary to help with your healthcare and/or with payment for your healthcare.

For example: We would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example would be when we would need to share your records of information to a specialist or a physician to whom you have been referred to, to ensure that the physician or specialist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health/dental care services, including from your family members or friends. For example: obtaining approval for a dental procedure from an insurance carrier that may require that your relevant protected health information be disclosed to the insurance plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities. For example: we may disclose your protected health information to dental/hygiene students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment via mail, phone, text and/or e-mail.

We may use or disclose your protected health information in the following situations without your authorization: These situations include: as Required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section l64.500.

HIPAA NOTICE OF PRIVATE PRACTICES (2 of 2)

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You Have The Right To Inspect And Copy Your Protected Health Information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You Have The Right To Request A Restriction Of Your Protected Health Information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your physician/dentist is not required to agree to a restriction that you may request. If physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You Have The Right To Request To Receive Confidential Communication From Us By An Alternative Means Or At An Alternative Location. You Have The Right To Obtain A Paper Copy Of This Notice From Us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You May Have The Right To Have Your Physician/Dentist Amend Your Protected Health Information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You Have The Right To Receive An Accounting Of Certain Disclosures We Have Made, If Any, Of Your Protected Health Information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. **We Will Not Retaliate Against You For Filing A Complaint.**

This notice was published and became affected on **April 14, 2003.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign this acknowledgement

I, _____ , have received a copy/explanation of this office's Notice of Privacy Practices.

Signature:_____Date:_____

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

Parent/Guardian Relationship to Patient:_____

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 barriers (such as a language barrier) prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgement at time of service

☐ Other (Please specify)_____