

DATE _____

PATIENT'S NAME _____ IF CHILD, PARENT'S NAME _____
LAST FIRST MI

DATE OF BIRTH _____ SSN # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ MOBILE # _____

BUSINESS # _____

E-MAIL ADDRESS _____

This will be used for recall reminders and advise you of specials and newsletters – we will keep your e-mail address confidential.

WHOM MAY WE THANK FOR THIS REFERRAL? _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY _____

DO YOU HAVE DENTAL INSURANCE? YES NO

NAME OF INSURANCE COMPANY _____

PHONE _____ GROUP # _____

POLICY HOLDER _____

EMPLOYER _____

DATE OF BIRTH _____ SSN # _____

PLEASE LIST ANY OTHER FAMILY MEMBERS _____

FOR OFFICE USE ONLY	
DATE OF INQUIRY _____	CONTACT NAME _____
EFFECTIVE DATE _____	GROUP # _____
NAME OF INSURANCE COMPANY _____	
ADDRESS _____	
PHONE _____	
ANNUAL MAXIMUM \$ _____	CALENDAR FISCAL
DEDUCTIBLE \$ _____	I F WAIVED FOR PREVENTATIVE? Y N
PREVENTATIVE _____ %	BASIC _____ % MAJOR _____ %
ORTHO Y N	ORTHO MAX \$ _____ ORTHO DED \$ _____ ORTHO _____ %
ORTHO COVERAGE FOR ADULTS? Y N ORTHO DEP THRU AGE _____	
D2391 POSTERIOR COMPOSITES COVERED? _____	
MISSING TOOTH CLAUSE? Y N	
COORDINATION OF BENEFITS? Y N	
IS THERE A WAITING PERIOD FOR MAJOR? Y N	
PROPHY INTERVAL _____ TO THE DATE? Y N	
EXAM INTERVAL _____ FMX/PANO INTERVAL _____	
BWV INTERVAL _____ PERIO MAINT (D4910) Y N INTERVAL _____	
SEALANTS Y N	UP TO AGE _____ FLUORIDE Y N UP TO AGE _____
SEALANTS WHICH TEETH? _____ FLUORIDE INTERVAL _____	
<u>HISTORY DATES</u>	
PROPHY _____	ELIGIBLE Y N DEBRIDEMENT (D4355) Y N
FMX _____	ELIGIBLE Y N
BWV _____	ELIGIBLE Y N IMPLANT PLACEMENT (D6010) Y N
FLUORIDE _____	ELIGIBLE Y N IMPLANT CROWN (D6066) Y N
EXAM _____	ELIGIBLE Y N
\$ COVERAGE REMAINING _____	DEDUCTIBLE MET? Y N

On all accounts, a finance charge of 1.5% per month (18% per year) will be charged on outstanding balances over 30 days. A minimum \$2.00 finance charge will be added to all accounts over 30 days. In the case of payment default I agree to pay attorneys fees and that there will be an additional charge of 40% of the balance owing to cover collections costs. I understand there may be a charge of \$25.00 applied to my account for canceling or breaking an appointment without 24 hours advance notice.

Release:

I authorize Dr. Bashi to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to Dr. Bashi, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for service. I understand I am financially responsible for payments in full of all accounts including any services that my insurance carrier may deem unnecessary. Please note: If your insurance carrier does not pay any claim within 60 days, we will require payment directly from you. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of all services not paid, in whole or in part by dental care payor.

PATIENT'S (IF MINOR - PARENT/GUARDIAN'S) SIGNATURE _____ DATE _____

REGISTRATION

**DENTAL HEALTH HISTORY
(CONFIDENTIAL)**

Patient Name _____
Last First Initial

Today's Date _____
Birth Date _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

Check () if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

MEDICAL HISTORY

Have you had any serious illnesses or operations? Yes No If yes, please describe _____

Have you ever had a blood transfusion? Yes No If yes, please give approximate date(s) _____

Are you currently taking or have you taken Bisphosphonates? Yes No

(Women) Are you pregnant? Yes No Taking birth control pills? Yes No

Check if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Diseases | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation Treatment | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | |

MEDICATIONS

List medications you are currently taking:

ALLERGIES

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Other _____ |

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

CHILD MEDICAL HEALTH HISTORY

Is child under care of physician now? If yes, please explain _____ _____ _____	Yes	No	Does your child have a heart murmur? _____	Yes	No
Is child receiving any medication or drugs? If yes, please explain _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Are there any emotional problems? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has child ever had surgery? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Is there any allergy to penicillin or other drugs? If yes, please explain _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
			Are there other allergies? (i.e. latex, food, pollen, animals, dust, other) _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

Does child have or had any history of the following? If yes, please check

- | | | | | |
|--|--|---------------------------------------|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Ashtma | <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Hearing | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Other, Please Explain |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney | <input type="checkbox"/> Mumps | _____ |

CHILD DENTAL HISTORY

Has child complained about dental problems? If yes, please explain _____ _____	Yes	No	Does your child brush teeth daily? _____	Yes	No
Any unhappy dental experiences? If yes, please explain _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you assist child with tooth brushing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any injuries to mouth, teeth, and/or head? If yes, please explain _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Is dental floss used? If yes, how often _____	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits? (i.e. thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier) If yes, please explain _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any unusual speech habits? _____	<input type="checkbox"/>	<input type="checkbox"/>	Child's overall attitude to dentistry _____ _____		
Orthodontic appliances worn now or previously? _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	_____ _____ _____		

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S / GUARDIAN'S SIGNATURE _____

DATE _____

DENTIST'S SIGNATURE _____

DATE _____

CHILD DENTAL / MEDICAL HISTORY

GENERAL CONSENT AND AGREEMENT

I have requested general dental treatment. I understand that oral health varies between individuals. Genetic and social factors may impact my oral health and may lead to some common dental conditions, including: calcification/plaque deposits on teeth; dental caries (cavities); gum disease; and gingivitis. I understand that to treat these conditions, my general dental care may include: teeth cleanings; x-rays; removal of decay; and placement of fillings. I also understand that in order to perform general dental care, I may require administration of local anesthetic. I understand that such dental treatment may relieve pain, improve my ability to chew properly, and give me a more aesthetically pleasing smile.

Generally, any dental procedure involves the following risks:

1. Drug or chemical reaction. Dental materials and medications may trigger allergic or sensitivity reactions. Although rare, such reactions could result in numbness, swelling, pain, infection, and may adversely affect health.
2. Long-term numbness (paresthesia). Local anesthetic, or its administration, can result in transient, or in rare instances, permanent numbness.
3. Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ order.
4. Sensitivity in teeth or gums, infection, or bleeding.
5. Inadvertently swallowing or inhaling small objects.

I understand that I may ask questions about all my dental procedures and that I should discuss any questions or concerns with my treatment providers.

I understand that if I am enrolled with an HMO dental plan that some services I receive will require a co-payment. The amount of my co-payment will vary according to the plan I have and the procedure that is performed. Additionally, if my plan has a yearly deductible I understand that it must be satisfied before the plan benefits begin for dental treatment. I further understand that dental services not covered under my plan may be prescribed in certain cases by HMO attending dentists. Non-member fees are charged for such services. Co-payments, deductibles, and any fee for service changes are subject to Dr. Bashi's regular financial arrangements. I understand there will be a \$25.00 charge for any missed appointment that is not cancelled 24 hours in advance.

CONSENT TO TREATMENT

Signature of Patient or Guardian (if Minor)

Date

Dr. Bashi

Date

V H Bashi DDS

6425 Wall Street
Colorado Springs, CO 80918
(719) 528-8292

PATIENT CONSENT

I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment;
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operation of your practice.

I have been given a copy of your *Notice to Privacy Practices* to review. I understand that you reserve the right to change the terms of this notice and I may contact you at any time to obtain the most current copy.

I understand that I have the right to request restrictions, in writing, on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

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 04/28/09 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 and 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 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 with your healthcare or with payment of 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 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 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 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 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 practicably 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 may charge you for each page and per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an 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 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, healthcare operation 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.

Restriction: 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.

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 complaint 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 Health and human Services.

Contact Officer: Mary Kliner
Telephone: (719) 528-8292 Fax: (719) 522-0288
E-mail: marykliner@qwestoffice.net
Address: 6425 Wall Street, Colorado Springs, CO 80918