THE CENTER FOR INNOVATIVE
DENTISTRY & FACIAL AESTHETICS

Yasaman S. Roland D.D.S. 133 Defense Hwy Suite 103 Annapolis, Maryland 21401

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify) _____

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PERMISSION TO TAKE PHOTOGRAPHS AND DIGITAL IMAGES (X-RAYS)

Patient Name

☐ I hereby authorize Dr. Yasaman Roland to take photographs and digital images (x-rays) of my face, jaws and the hard and soft tissues of my mouth.

☐ I understand that these photographs and digital images (x-rays) will be part of my permanent dental records.

☐ I also understand that these photographs and digital images (x-rays) may be used for educational purposes in lectures, demonstrations, and professional publications and I hereby authorize said use.

Patient Signature Date

Parent or Guardian Signature Date

Staff Member / Date

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DENTAL HISTORY

Patient Name _____

Y / N		Y / N	
☐ / ☐	Do your gums bleed when brushing?	☐ / ☐	Do you frequently snack on sweets on chew gum?
☐ / ☐	Are your teeth sensitive to? Heat Cold Sweets Biting Pressure	☐ / ☐	Do any of your fillings show in your front teeth?
☐ / ☐	Do you avoid any part of your mouth when brushing?	☐ / ☐	Do you have a concern about fear on discomfort?
☐ / ☐	Does food constantly get stuck between certain teeth in your mouth?	☐ / ☐	Do any of your fillings show when you smile?
☐ / ☐	Have you been instructed regarding propex oral hygiene?	☐ / ☐	If any of your mercury metal fillings need replacement, would you prefer to have a more natural, tooth-colored restoration instead?
☐ / ☐	Are you dissatisfied with your teeth in any way?	☐ / ☐	Have you ever had any teeth removed?
☐ / ☐	Do you have an unpleasant taste or odor in y our mouth?	☐ / ☐	De you play Sports, if yes what type
☐ / ☐	Are you dissatisfied with the way your teeth look? For example: color, shape, spaces,		

When was your last dental appointment? _____

How long has it been since you have had a full series of x-rays? _____

What has prompted you to seek dental care at this time? _____

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Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Date of birth: _____ Social Security Number: _____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer: _____

Employer Address: _____

Work Phone: _____

Name of emergency contact: _____ Contact # _____

Name of person responsible for this account: _____

Relationship to patient: _____

DENTAL INSURANCE INFORMATION FOR YOUR REIMBURSEMENT:

Name of Primary Insurance Company: _____

Address: _____

Group #: _____ ID# _____

Name of cardholder: _____ DOB _____

Cardholder Social Seccurity # _____ Employer: _____

Address: _____

Name of Secondary Insurance Company: _____

Address: _____

Group #: _____ ID# _____

Name of cardholder: _____ DOB _____

Cardholder Social Seccurity # _____ Employer: _____

Address: _____

Whom may we thank for referring you? _____

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MEDICAL HISTORY

PATIENT NAME:_____ DOB: _____

SEX: _____ HEIGHT: _____ WEIGHT: _____

Y / N		Y / N		Y / N	
☐ / ☐	BNORMAL BLEEDING	☐ / ☐	HEPATITIS C	☐ / ☐	CODEINE
☐ / ☐	GLAUCOMA	☐ / ☐	SMOKE/USE TOBACCO	☐ / ☐	DIFFICULTY BREATHING
☐ / ☐	SINUS PROBLEMS	☐ / ☐	ASTHMA	☐ / ☐	PNEUMOCYSTITIS
☐ / ☐	ALCOHOL ABUSE	☐ / ☐	HIGH BLOOD PRESSURE	☐ / ☐	DENTAL ANESTHETICS
☐ / ☐	HAY FEVER		FEMALE INFORMATION	☐ / ☐	DRUG ABUSE
☐ / ☐	STROKE	☐ / ☐	BLOOD TRANSFUSION	☐ / ☐	PSYCHIATRIC PROBLEMS
☐ / ☐	ALLERGIES	☐ / ☐	HIV & AIDS	☐ / ☐	ERYTHROMYCIN
☐ / ☐	HEART ATTACK	☐ / ☐	BIRTH CONTROL	☐ / ☐	EMPHYSEMA
☐ / ☐	THYROID PROBLEMS	☐ / ☐	CANCER CHEMOTHERAPY	☐ / ☐	RADIATION THERAPY
☐ / ☐	ANEMIA	☐ / ☐	KIDNEY PROBLEMS	☐ / ☐	JEWELRY
☐ / ☐	HEART SURGERY	☐ / ☐	PREGNANT	☐ / ☐	EPILEPSY
☐ / ☐	TUBERCULOSIS	☐ / ☐	COLITIS	☐ / ☐	RHEUMATIC FEVER
☐ / ☐	ANGINA PECTORIS	☐ / ☐	LIVER DISEASE	☐ / ☐	LATEX
☐ / ☐	HEMOPHILIA	☐ / ☐	NURSING	☐ / ☐	FAINTING SPELLS
☐ / ☐	ULCERS	☐ / ☐	CONGENITAL HEART DEFECT	☐ / ☐	SEIZURE
☐ / ☐	ARTHRITIS	☐ / ☐	LOW BLOOD PRESSURE	☐ / ☐	METALS
☐ / ☐	HEPATITIS A		ALLERGIES	☐ / ☐	FEVER BLISTERS
☐ / ☐	VENEREAL DISEASE	☐ / ☐	COSMETIC SURGERY	☐ / ☐	SHINGLES
☐ / ☐	ARTIFICIAL BONES	☐ / ☐	MITRAL VALVE PROLAPSE	☐ / ☐	PENICILLIN
☐ / ☐	HEPATITIS B	☐ / ☐	ASPIRIN	☐ / ☐	FREQUENT HEADACHES
☐ / ☐	YELLOW JAUNDICE	☐ / ☐	DIABETES	☐ / ☐	SICKLE CELL DISEASE
☐ / ☐	ARTIFICIAL HEART VALVES	☐ / ☐	PACE MAKER	☐ / ☐	TETRACYCLINE

Other: _____

Are you currently taking any medications (including aspirin) ? If yes please list: _____

_____

Is there any disease, condition or problem that you think this office should know about that is not covered above? above?

If yes please explain: _____

_____

Signature: _____ Date: _____

(PARENT OR GUARDIAN IF UNDER 18)

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In order to serve you better, please take a moment to review our office cancellation policy.

It is our hope that you will always be able to make your appointments. It is time that has been reserved for you. We know that these days our lives have become very hectic and that is why we will always try and give yiur a COURTESY confirmation call one or two days before your scheduled appointment.

When a patient does not show up for an appointment or does not give enough notice to our staff that they are unable to keep their appointment it takes away the opportunity for another patient to be seen and does not allow our staff adequate time to try and schedule someone else in that time slot. Please try and give our staff at least 48 hours notice if you will need to change a scheduled appointment. If 48 hours is not given and $50.00 cancellation fee will apply.

Thank you for your coorperation.

Signature: _____ Date: _____

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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 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 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 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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.

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 Health and Human Services.