Annik Ohaness, RDHAP 818.288.1083

Annik012001@yahoo.com

Patient's Health Information

Patient's Name: _____ Sex: __M __F DOB: ____/____/_____
Address/Facility Address: _____
Facility Name: _____ Facility Contact: _____
Phone: _____ Email: _____

DENTAL HISTORY

Name of Dentist: _____
Date of Last visit & type of treatment: _____
Check if you have problems with any of the following:
__ Bad Breath/ Bleeding gums __ Dry mouth __ Sores or growth in your mouth
__ Food collection between teeth __ Loose teeth __ Ill-fitting partial/denture
__ Other (Please describe)

MEDICAL HISTORY

Name of Physician: _____ Medical Group: _____
Address: _____
MR #: _____ Phone: _____ Email: _____
Are you taking bone density medications or bisphosphonates, such as Fosamax, Boniva, Actenol or IV: Zometa or Aredia in the past 12 years?
__ Yes __ NO

Indicate which of the following you have had or have at present: _ Blind _ Deaf _ Disabled

__ Alzheimer's Disease	__ Bruise easily	__ Emphysema	__ Jaundice	__ Sickle Cell Disease
__ AIDS/HIV	__ Cancer/ Chemotherapy	__ Epilepsy/ Seizures	__ Kidney Trouble	__ Sinus Trouble
__ Alcohol/ Drug Abuse	__ Chest Pain	__ Fainting or Dizzy Spells	__ Liver Disease	__ Snoring/ Sleep Apnea
__ Allergies or Hives	__ Circulatory Problem	__ Frequent Headaches	__ Lupus	__ Stomach Problems
__ Anemia	__ Cold Sores/Herpes	__ Glaucoma	__ Mitral Valve Prolapse	__ Stroke
__ Arthritis/ Rheumatism	__ Cortisone Medicine	__ Heart Pacemaker	__ Nervousness/Anxiety	__ swollen Ankles
__ Artificial Heart Valve	__ Deaf/ Haring loss	__ Heart Problem	__ Neurological Disorder	__Thyroid Problems
__ Artificial Joints **	__ Dementia	__ Hemophilia	__ Parkinson's	__ Tuberculosis
__ Asthma	__ Diabetes	__ Hepatitis A B C	__ Rheumatic Fever	__ Tumors
__ Blood Disease	__ Diet (Special/Restricted)	__ High/Low Blood Pressure	__ Radiation Therapy	__ Ulcer
__ Back/Neck Issues	__ Difficulty Breathing	__ Hospitalized for any Reason	__ Shingles/ Chicken Pox	__ Venereal Disease

If YES to ATIFICIAL JOINTS (HIP/ JOINT REPLACEMENT), an antibiotic **MAY** be required 1 hour prior to appointment. Please have the **MD** prescribe the appropriate antibiotic and have ready on the day of treatment. Take the antibiotic 1 hour prior to the scheduled appointment.
Any other medical conditions not listed:_____

Allergies: __Aspirin __ Penicillin __ Barbiturates (sleeping pills) __ Sulfa __ Codeine __ Latex __ Local Anesthetic

Other_____

List all medications: _____

_____

The above information is accurate to the best of my knowledge. Annik Ohaness, RDHAP, is not responsible for any errors or omissions that I have made while completing this form.

Signature _____ Printed Name_____ Date: _____

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CONSENT FOR DENTAL HYGIENE TREATMENT

Patient Name:_____ Sex:__M __F Date: _____
Facility Name: _____Phone #: _____
Address: _____
City/State: _____ Zip Code: _____
SSN: _____ - _____- _____ DOB: ____/____/_____ Room #: _____ Facility Lic #: _____
Medicare #: _____ Medi-Cal #: _____

Full payment is required from the responsible party at the time of service unless arrangements are made in advance. **A super-bill can be provided for reimbursement from your dental insurance provider.**

Prophy & Deep Cleaning Fees Include: Infection Control, Fluoride, Head & Neck/ Oral Cancer Exam, Oral Hygiene Instructions, Dental Hygiene Supplies, Travel, Administrative, and DDS/MD/RN consultation.

I request to have dental cleaning every: __ 3 Months __ 4 Months __ 6 Months

Privacy Practices

THIS NOTICE DESCTIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. In accordance with the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to maintain the confidentiality of your health information. We realize that these laws are complicated, but we **must provide you with the following important information that describes how we may use and disclose your protected health information to carry** out treatment, payment of health care operation, and for other purposes that we are permitted or required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your dental care and related services. For example, your health /dental information may be provided to a dentist to whom you have been referred, to ensure that the dentist has the information necessary to diagnose or treat you.

In addition, we may disclose your protected health information periodically to another dentist, physician, or health care provider who becomes involved in your care. We may use and disclose dental information about you to obtain payment for services rendered. Such disclosures may be made to you, and insurance company, responsible party, or third party. We may also tell your health plan about a treatment you are going to receive to obtain approval or to determine whether your plan will cover treatment.

_ I give consent for dental hygiene and preventive treatment for the patient.
_ I reviewed the Privacy Practices above.
_ Permission is granted for Review of Medical Records.
_ Permission is granted to take pictures and/or video of patient for chart ID, or educational purposes.
Email address may be used to receive communications and/or other pertinent information.

All fees are ultimately the responsibility of the "Financial Responsible Party."

Name of Responsible Party: _____
Relationship to Patient: _____
Mailing /Billing Address: _____
City/State/Zip Code: _____
Phone #: _____ Email: _____

Signature of Responsible Party/ POA for Healthcare_____ Date:_____
Signature of the Financial Responsible Party _____ Date: _____

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Patient Information Form

Patient Name (Mr./Mrs./Ms.): _____ DOB: _____ SS# _____

Home Address:_____

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

Email: _____

Employer: _____

Primary Insurance Information:

Name of subscriber: _____ Relationship: _____

Subscriber's Employer: _____

Name of Insurance Co: _____ SS# of subscriber: _____

Phone # of Insurance Co: _____ Group #: _____ DOB of subscriber: _____

Secondary Insurance Information:

Name of Subscriber: _____ Relationship: _____

Subscriber's Employer: _____

Name of Insurance Co: _____ SS# of subscriber: _____

Phone # of Insurance Co: _____ Group #: _____ DOB of subscriber: _____

Who should we contact in case of emergency:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Name of responsible party: _____

Address: _____City ,State, Zip:_____

Phone: _____ Email Address_____

I will be paying for services by: ____ CASH ____ CHECK ____ DENTICAL

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information and have completed the form. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my health or any changes in the above information.

Signature: _____ **Date:_____**