Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____Email: _____Referred by: _____

Cell Phone: _____Home Phone:_____ Business Phone:_____

Mailing address: City: State Zip:

Emergency Contact Name & Phone Number: **Date of Birth:**

Do you have any of the following diseases or problems: (check Dk if you don't know)	Yes/No/Dk
Active Tuberculosis	○○○
Persistent cough greater than a 3 weeks duration	○○○
Cough that produces blood	○○○
Been exposed to anyone with tuberculosis	○○○

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information -- Please mark (X) your responses to the following questions:

	Yes/No/DK		Yes/No/DK
Do your gums bleed when you brush or floss?	○○○	Do you have earaches or neck pain?	○○○
Are your teeth sensitive to cold, hot, sweets or pressure?	○○○	Do you have any clicking, popping, or discomfort in the jaw?	○○○
Is your mouth dry?	○○○	Do you brux or grind your teeth?	○○○
Have you had any periodontal (gum) treatments?	○○○	Do you have sores or ulcers in your mouth?	○○○
Have you ever had orthodontic (braces/Invisalign) treatments?	○○○	Do you wear dentures or partials?	○○○
Have you had any problems previous dental treatment?	○○○	Do you participate in active recreational activities?	○○○
Is your home water supply fluoridated?	○○○	Have you ever had a serious injury to your head or mouth?	○○○
Do you drink bottled or filtered water?	○○○	Are you experiencing dental pain or discomfort?	○○○
Date of last dental exam:		Last dentist name/phone#:	
Date of last dental x-ray:		Address:	

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Medical Information-- Please mark (X) your response to indicate if you have or have not had any of the following.

	Yes/No/DK		Yes/No/DK
Are you under the care of a physician?.....	○○○	Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	○○○
Physician Name: Phone: ( )		If yes, what was the illness or problem?	
Address/City/State/Zip:		Are you taking, or have you recently taken any prescription/ over the counter medicine(s)?.....	○○○
Has there been any changes in your health within the past year?.....	○○○	If so, please list all, including vitamins, natural or herbal preparations, recreational substances and/or diet supplements:	
If under the care of a physician, what condition is being treated?		_____	
Date of last physical exam:		_____	
		_____	

Medical Information **Please mark (X) your response to indicate if you have or have not had any of the following:**

(check DK if you don't know the answer to the question)	**Yes/No/DK**		**Yes/No/DK**
Joint replacement. Have you had an orthopedic total joint (hip, knee, elbow, figure) replacement? ……. Date: _____ If yes, have you had any Complications?	○○○	Do you use tobacco (smoking, snuff, chew, bidis)? …… If so, how interested are you in stopping? Circle one **(Very, Somewhat, Not Interested)**	○○○
Are you taking or scheduled to begin taking either of the medication, alendronate (Fosamax®), Risedronate (Actonel®) for Osteoporosis or Paget's disease?	○○○	Do you drink alcoholic beverages? ..... If yes, how much in the last 24 hours? ..... If yes, how much do you drink in a week? …….	○○○
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's diseases, multiple myeloma or metastatic cancer? …… Date treatment began: ……	○○○	**Women Only…. Are you?** Pregnant?..... Number of weeks: …… Nursing? …… Taking birth control pills …… Name of medication …….. Hormonal replacements: …… Name of medications ……..	**Yes/No/DK** ○○○ ○○○ ○○○ ○○○

Allergies: Are you allergic to? If yes specify reaction	**Yes/No/DK**		**Yes/No/DK**
Local Anesthetics:	○○○	Metals:	○○○
Aspirin:	○○○	Latex (rubber):	○○○
Penicillin or other antibiotics:	○○○	Iodine:	○○○
Barbiturates, sedatives, or sleeping pills:	○○○	Hay fever/Seasonal allergy:	○○○
Sulfa drugs:	○○○	Animals:	○○○
Codeine or other Narcotics:	○○○	Food:	○○○
Recreational Drugs:	○○○	Other:	○○○

Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

	Yes/No/DK		**Yes/No/DK**		**Yes/No/DK**
Artificial (prostatic) heart valve	○○○	Damaged heart valves	○○○	Rheumatic fever	○○○
Previous infective endocarditis	○○○	Arteriosclerosis	○○○	Abnormal bleeding	○○○
Damaged valves in transplanted heart	○○○	Heart murmur	○○○	Anemia	○○○
Congenital heart disease (CHD)	○○○	High blood pressure	○○○	Blood Transfusion	○○○
Cardiovascular disease	○○○	Low blood pressure	○○○	If yes, date:	○○○
Heart attack	○○○	Mitral valve prolapses	○○○	Hemophilia	○○○
Angina	○○○	Pacemaker	○○○	AIDS or HIV infection	○○○
Congestive heart failure	○○○	Rheumatic heart disease	○○○	Chest pain upon exertion	○○○
Autoimmune disease	○○○	Diabetes type I or type II	○○○	Stroke	○○○
Rheumatoid arthritis	○○○	Eating disorder	○○○	Glaucoma	○○○
Asthma	○○○	Malnutrition	○○○	Hepatitis, jaundice, liver disease	○○○
Bronchitis	○○○	Gastrointestinal disease	○○○	Epilepsy	○○○
Emphysema	○○○	G.E. Reflux/heartburn	○○○	Fainting spells, seizures	○○○
Sinus Trouble	○○○	Ulcers	○○○	Neurological disorder	○○○
Chronic pain	○○○	Thyroid disorder	○○○	Sleep disorder	○○○
Mental health disorder	○○○	Recurrent infections	○○○	Kidney Problems	○○○
Specify……		Specify……		Night sweats	○○○
Persistent swollen glands	○○○	Osteoporosis	○○○	Severe headache/Migraines	○○○
Severe or rapid weight loss	○○○	Excessive urination	○○○	Sexually transmitted disease	○○○
Cancer	○○○	Chemotherapy	○○○	Radiation	○○○

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes○..... No○..... DK○.....

Name and telephone number of the Dentist/Medical doctor making this recommendation. ……

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that Dr. Samsavar and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold Dr. Samsavar, or any member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:	Date:

Financial Policy

Thank you for choosing Dr. Samsavar as your dental healthcare provider. We are committed to providing the best dental care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy, which we ask you to read, sign, and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by Dr. Samsavar.
- All applicable co-pays, persona balances, both current and prior, are due at the time of service or upon receipt of the invoice.
- We accept cash, check, or credit cards.

Regarding Insurance

Dental insurance is considered an agreement between you and your insurance company; therefore, we can only estimate your dental benefits. The estimate is not a guarantee of payment by your insurance company. You are responsible for all the charges.

We will file all insurance claims with the insurance provider you supply our office with. Please be sure to update our office of any changes in your insurance. We participate in some insurance plans; however, we require that the person who is financially responsible, is personally liable for all balances. It is your responsibility to understand and comply with any Pre-determination of benefits or referral requirements.

If you are uncertain about your current insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket expenses and, coverage limits. Initials: _____

Cost of Treatment

Treatment plans are customized for your individual care. To that end, we want you to be aware of your financial investment into your care and do so by providing estimates of expenses. Please understand that any estimate given is just an estimation of costs as there are many factors that contribute to the treatment. Initials: _____

Missed Appointments

Dr. Samsavar requires 48 hours' notice of appointment cancelation. Appointments missed and are not previously canceled may be charged a fee of $75.00 Initials: _____

Minors

The parent(s), guardian(s), or financial guarantor is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors. Initials: _____

Past Due Accounts

I/We agree to pay all attorney fees, court costs, and filing fees, which may be assessed by any collection agency or law firm retained to pursue the matter. Additionally, past due balances shall accrue interest at the rate of twelve (12%) percent per annum. Initials: _____

Accounting Principals

Payments and Credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding services.

Initials: _____

Address Changes

It is our policy to provide invoices for any amounts owed on your account. We send all correspondence to the address information you provide, so please advise us anytime there is a change to your address, telephone number, email, or other contact information. Initials: _____

Returned Check

For checks returned to us as unpaid by your bank. We will charge a $50 fee. Please contact our office if you have any questions or concerns at 425-990-832

- **I authorize Dr. Samsavar to release pertinent dental information to my insurance company when requested or to facilitate payment of a claim.**
- **I authorize my insurance benefits to be paid directly to Dr. Samsavar.**
- **I have read the financial policy. I understand and agree with the financial policy.**

Signature of Patient/Legal Guardian:	Date:

I have received and understand Dr. Samsavar's Notice of Privacy Practice written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that made by this practice, my individual rights, how I may exercise these rights, and the legal duties with respect to my information.

Print Name:_____

Signature of Patient/Legal Guardian:	Date:

Aalam Samsavar DDS PS

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on 01/01/2020 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records, may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

-Prevent or control disease, injury, or disability.

-Report child abuse or neglect.

-Report reactions to medications or problems with products or devices.

-Notify a person of a recall, repair, or replacement of products or devices.

-Notify a person who may have been exposed to a disease or condition; or

-Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors

consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt-out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying and for the postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. Except for certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in 12 months, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (admin@drsamsavar.com).

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 if 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.

Privacy Official: Aalam Samsavar DDS
Tel: 425 990 8321 Fax: 425-990-8323
Address: 10223 NE 10th St. Suite E Bellevue WA 98004
E-mail: info@drsamsavar.com
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.