

Health History Form

E-mail: _____	Today's Date: _____
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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: _____ <small>Last First Middle</small>	Home Phone: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()
Address: _____ <small>Mailing address</small>	City: _____	State: _____ Zip: _____
Occupation: _____	Height: _____ Weight: _____	Date of birth: _____ Sex: M F
SS# or Patient ID: _____	Emergency Contact: _____	Relationship: _____ Home Phone: () Cell Phone: () <small>Include area codes</small>

If you are completing this form for another person, what is your relationship to that person?

Your Name _____	Relationship _____
Do you have any of the following diseases or problems: <i>(Check DK if you Don't Know the answer to the question)</i>	
Active Tuberculosis.....	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
Cough that produces blood.....	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.	

Who may we thank for referring you to our office? _____

Dental Information For the following questions, please mark (X) your responses to the following questions.

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

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Dr's Kirsch and Moradi DDS

Informed Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provided your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medications, pre and post treatment instructions, referrals to other dentists or specialists, and in return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so she/he can consult with your physician if necessary. The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and occur occasionally. Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling and discomfort after treatment.
2. Infection in need of medication, follow-up procedure or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultations by a dental specialist.
9. Jaw fracture.
10. If upper teeth are treated, there is a chance of sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
11. Allergic reaction to anesthetic or medication.
12. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient Signature: _____

Date: _____

Witness: _____

Printed Patient Name: _____

Parent/Legal Guardian: _____

Notice of Privacy Policy

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.

K&M Dental (Pershin Moradi DMD & Steven Kirsch, DDS)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location and provide patients with a written Notice of Privacy Policy.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice, at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy Policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from HIPAA Coordinator listed in our written HIPAA Plan.

USES AND DISCLOSURES OF THE HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

Treatment Services: We may use or disclose your health information to all of our staff members, other dentists, your physicians and other health care providers taking care of you.

Payment and Health Care Operations: We may use and disclose your health information to obtain payment for services provided to you, to participate in quality assurance, disease management, training, licensing and certification programs.

Marketing: We will not use your health information for marketing purposes without your written consent.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, email, postcards, or letters.

Legal Requirements: We may disclose your health information when required to do so by law.

Abuse or Neglect: If abuse or neglect is reasonably suspected, we may disclose your health information to the appropriate governmental authorities.

National Security: When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal officials when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may also be provided to correctional institutes.

Family Members, Friends, and Others Involved in Care: At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgement as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver or personal representative of your location, condition or death.

Business Associates: Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Research: We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and

determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.

Public Health Activities: Occasionally, we may disclose medical information for public health activities. These activities include the following: to prevent or control disease, injury or disability; to report reactions with medications or problems with products, to notify people of recalls or products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease or condition; to notify the proper government authority if we believe a patient has been the victim of acute, neglect, or domestic violence (only when required by law).

Note: 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 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.

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. We will charge you a reasonable cost-based fee for expenses such as copies. If you request x-rays, you are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.
- **Accounting of Disclosures:** 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.
- **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 would be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us using the contact information listed at the end of this Notice. You may also submit a written complaint to the DHHS. We will provide you with the address to file your complaint with the DHHS 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 the DHHS.

Dr's Steven Kirsch and Pershin Moradi

24400 Muirlands Blvd., Suite D

Lake Forest, CA 92630

HIPAA Right Access Form for Family Member/Friend

I, _____, acknowledge I have received (or been offered) a copy of this office Notice of Privacy Practices. By signing this form, you are giving your consent to use and disclose health information about you for treatment, payment, and health care operation purposes. Below, I direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:	Relationship:	Contact number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Information to be disclosed upon the request of the person named above –

(Check either A or B)

- A. Disclose my complete health record (including but not limited to diagnoses, prognosis, treatment, and billing, for all conditions)
- B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):
 - Mental health records
 - Communicable diseases (including HIV and AIDS)
 - Alcohol/drug abuse treatment
 - Other (please specify): _____

This authorization shall be effective until (check one):

- All Past, present, and future periods OR
- Date or event: _____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your dental provider, in writing)

Name of Individual Giving Authorization

Date of birth

Signature

Date

FINANCIAL AGREEMENT

STEVEN KIRSCH, DDS & PERSHIN MORADI, DMD

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance that I may have is based on a *contract between my insurance company and me, my spouse and/or my employer*. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance information and any changes thereto.

All returned checks will be subject to a \$25 returned check fee. Any account balances that remain unpaid for 90 days from the date of service shall accrue interest at the rate of 11% per month and may be referred to a collection company or attorney. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith. I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith. I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office. Patient: Print Name:

Print name: _____ Date: _____

Signature: _____

Guardian/Responsible Party, if minor: _____ Date: _____

Signature: _____