PATIENT MEDICAL HISTORY & UPDATE FORM

Date: _____

Patient Name: _____ DOB: _____

Address: _____City, State, Zip code: _____

Home: (___) _____ Cell: (___) _____ Work: (___) _____

Email: _____

Can we email you or text you to confirm your appointments? YES ____ NO _____

If yes, email only _____ text only _____ both _____

What is the best way to contact you in case of an emergency? _____

Dental Insurance (If different): _____

Pharmacy Name: _____ Phone: (___) _____

Primary Care Physician: _____ Phone: (___) _____

Emergency Contact: _____ Phone: (___) _____ Relationship: _____

Do you have, or have you had, any of the following? Please check Yes or No:

❑ Yes ❑ No AIDS/HIV Positive
❑ Yes ❑ No Anaphylaxis
❑ Yes ❑ No Anemia
❑ Yes ❑ No Angina
❑ Yes ❑ No Arthritis/Gout
❑ Yes ❑ No Artificial Heart Valve
❑ Yes ❑ No Artificial Joint
❑ Yes ❑ No Asthma
❑ Yes ❑ No Blood Disease
❑ Yes ❑ No Blood Transfusion
❑ Yes ❑ No Breathing Problem
❑ Yes ❑ No Easily Winded
❑ Yes ❑ No Heart Pacemaker
❑ Yes ❑ No Heart Trouble/Disease
❑ Yes ❑ No Hemophilia
❑ Yes ❑ No Hepatitis A
❑ Yes ❑ No Hepatitis B or C
❑ Yes ❑ No Herpes
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No High Cholesterol
❑ Yes ❑ No Hives or Rash
❑ Yes ❑ No Hypoglycemia
❑ Yes ❑ No Irregular Heartbeat
❑ Yes ❑ No Kidney Problems
❑ Yes ❑ No Leukemia
❑ Yes ❑ No Liver Disease
❑ Yes ❑ No Alzheimer's disease
❑ Yes ❑ No Bruise Easily
❑ Yes ❑ No Cancer
❑ Yes ❑ No Chemotherapy
❑ Yes ❑ No Chest Pains
❑ Yes ❑ No Cold Sores/Fever Blisters
❑ Yes ❑ No Congenital Heart Disorder
❑ Yes ❑ No Convulsions
❑ Yes ❑ No Cortisone Medicine
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Drug Addiction
❑ Yes ❑ No Emphysema
❑ Yes ❑ No Low Blood Pressure
❑ Yes ❑ No Lung Disease
❑ Yes ❑ No Mitral Valve Prolapsed
❑ Yes ❑ No Osteoporosis
❑ Yes ❑ No Pain in Jaw Joints
❑ Yes ❑ No Parathyroid Disease
❑ Yes ❑ No Psychiatric Care
❑ Yes ❑ No Radiation Treatments
❑ Yes ❑ No Recent Weight Loss
❑ Yes ❑ No Renal Dialysis
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Rheumatism
❑ Yes ❑ No Scarlet Fever
❑ Yes ❑ No Shingles
❑ Yes ❑ No Epilepsy or Seizures
❑ Yes ❑ No Excessive Bleeding
❑ Yes ❑ No Excessive Thirst
❑ Yes ❑ No Fainting Spells/Dizziness
❑ Yes ❑ No Frequent Cough
❑ Yes ❑ No Frequent Diarrhea
❑ Yes ❑ No Frequent Headaches
❑ Yes ❑ No Genital Herpes
❑ Yes ❑ No Glaucoma
❑ Yes ❑ No Hay Fever
❑ Yes ❑ No Heart Attack/Failure
❑ Yes ❑ No Heart Murmur
❑ Yes ❑ No Sickle Cell Disease
❑ Yes ❑ No Sinus Trouble
❑ Yes ❑ No Spinal Bifida
❑ Yes ❑ No Stomach/intestinal Disease
❑ Yes ❑ No Swelling of Limbs
❑ Yes ❑ No Thyroid Disease
❑ Yes ❑ No Tonsillitis
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Tumors or Growths
❑ Yes ❑ No Ulcers
❑ Yes ❑ No Venereal Disease
❑ Yes ❑ No Yellow Jaundice

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain _____

Patient Signature: _____ Date: _____

RADIOGRAPHIC (X-RAYS) & CLINICAL EXAMINATION CONSENT

PATIENT NAME: _____ DOB: _____

DENTAL PROVIDER: DEEPALI VERMA, D.D.S.

I give the team at Verma Cosmetic & Family Dentistry permission to perform the following in order to get a complete dental health assessment.

- **Radiographs (x-rays)**
- **Photographs of teeth**
- **Periodontal Measurements**
- **Charting of Existing Restorations**
- **Diagnostic Cast (models of teeth)**
- **Bite Records**

Furthermore, I authorize Dr. Verma to conduct a complete exam of the dental condition included but not limited to

- **American Cancer Society Head/Neck (intraoral/ extra oral) cancer screening**
- **TMJ evaluation**
- **Sleep Apnea Evaluation**
- **Periodontal Evaluation**
- **Complete Inventory of Existing Restorations**
- **Radiographic Evaluation of Oral / Head/Neck Structures as Needed**
- **Evaluation of Occlusion of Teeth**
- **The Development of Personalized life-long Plan for Dental Health**

Patient/ Guardian Printed Name: _____

Patient / Guardian Signature: _____ Date: _____

Witness/ Staff Signature: _____ Date: _____

Verma
COSMETIC & FAMILY DENTISTRY

OralID™

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the Oral ID™ screening device into our office. The Oral ID™ examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the Oral ID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection
- Previous History of Cancer

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the Oral ID.

Our office charges **$20.00** per screening with the Oral ID.

___ Yes,

I request that your staff perform an examination with the Oral ID. I accept financial responsibility for this examination.

Patient Signature: _____Patient Name: _____Date: _____

___No,

I prefer to not have this examination at this visit.

Patient Signature: _____Patient Name: _____Date: _____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. Outside financing is available upon request and approval.

Please note: Additional fees will be applied for returned checks. All account balances over 90 days are subject to a $35.00 late fee.

Do you have insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the 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.

Continued….

Patient Treatment and Financial Policy

- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express and CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

Missed Appointment (s) and Cancellations: Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Patient/ Guardian Printed: _____

Patient/ Guardian Signature: _____ Date: _____

STOP-BANG
Sleeping Disorder Questionnaire

S (snore)	Do you SNORE?	Yes	No
T (tired)	Do you often feel TIRED or sleepy during the daytime?	Yes	No
O (observed)	Has anyone OBSERVED you stop breathing during your sleep (even once)?	Yes	No
P (pressure)	Do you have or are you being treated for high blood PRESSURE?	Yes	No

B (bmi)	Is your Body Mass Index (BMI) more than 35?	Yes	No
A (age)	Is your AGE over 50 years old?	Yes	No
N (neck)	Is your NECK circumference 16 inches or greater?	Yes	No
G (gender)	Is your GENDER male?	Yes	No

Weight: _____
Height: _____
BMI: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all.

Such uses or disclosures are:

When a state or federal law mandates that certain health information be reported for a specific purpose;
for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and
from the federal Food and Drug Administration regarding drugs or medical devices; disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws; disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies; disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else; disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations; uses or disclosures for health related research; uses and disclosures to prevent a serious threat to health or safety; uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service; disclosures of de-identified information; disclosures relating to worker's compensation programs; disclosures of a "limited data set" for research, public health, or health care operations; incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

Continued…..

OTHER USES AND DISCLOSURES
We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
The law gives you many rights regarding your health information.
You can:

Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES
By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS
If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION
If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

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.

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

__Communications barriers prohibited obtaining the acknowledgement

__An emergency situation prevented us from obtaining acknowledgement

__Other (Please Specify)

_____

_____

_____