Advanced Dentistry of CT

Reza Radmand, DMD, FAAOM

Patient Registration

Today's Date: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐Policy Holder ☐Responsible Party

How were you referred to our practice? _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Soc. Sec: _____ Driver's Lic: _____

☐Responsible Party is also a policy holder for patient

☐Primary Insurance Policy Holder ☐Secondary Insurance Policy Holder

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Patient Information

Address: _____ City: _____

State/Zip: _____ Home Phone: _____

Cell Phone: _____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Birth Date: _____ Age: ____ Social Sec.: _____ Driver's License: _____

E-mail: _____ ☐ I would like to receive correspondences via email

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Employment Status: ☐Full Time ☐Part Time ☐Retired

Student Status: ☐Full Time ☐Part Time ☐Retired

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Physician Name: _____

Physician #: _____

Emergency Contact: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Advanced Dentistry of CT

Reza Radmand, DMD, FAAOM

Patient Medical History

Today's Date: _____

Patient Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes: _____

Do you take, or have you taken, Xgeva? ☐ Yes ☐ No If yes: _____

Have you ever taken Fosamax, Boniva, Acetonel, or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes: _____

Are you on a special diet? ☐ Yes ☐ No If yes: _____

Do you use tobacco? ☐ Yes ☐ No If yes: _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ Other

Do you use controlled substances? ☐ Yes ☐ No If yes: _____

Snoring and Sleep:

Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No If yes: _____

Have you ever had a sleep study? ☐ Yes ☐ No If yes: _____

Have you ever used an oral appliance for sleep? ☐ Yes ☐ No If yes: _____

Have you ever been told that your breathing stops or severely diminishes during sleep? ☐ Yes ☐ No If yes: _____

Have you ever used a CPAP device? ☐ Yes ☐ No If yes: _____

Do you wake up multiple times during sleep? ☐ Yes ☐ No If yes: _____
If so how many times? _____

Do you generally feel tired and fatigued after you wake up? ☐ Yes ☐ No If yes: _____

Do you ever nod off or feel sleepy during the day while sitting or reading? ☐ Yes ☐ No If yes: _____

Have you ever nodded off or fallen asleep while driving? ☐ Yes ☐ No If yes: _____

Do you have, or have you had, any of the following?

☐AIDS/HIV Positive
☐Alzheimer's Disease
☐Anaphylaxis
☐Anemia
☐Angina
☐Arthritis/Gout
☐Artificial Heart Valve
☐Artificial Joint
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Breathing Problems
☐Bruise Easily
☐Cancer
☐Chemotherapy
☐Heart Attack/Failure
☐Heart Murmur
☐Heart Pacemaker
☐Heart Trouble/Disease
☐Auto Immune Disease
☐Cortisone Medicine
☐Diabetes
☐Drug Addiction
☐Easily Winded
☐Emphysema
☐Epilepsy/Seizures
☐Excessive Bleeding
☐Excessive Thirst
☐Faints/Dizziness
☐Frequent Cough
☐Frequent Diarrhea
☐Frequent Headaches
☐Genital Herpes
☐Glaucoma
☐Hay Fever
☐Osteoporosis
☐Pain in Jaw Joints
☐Parathyroid Disease
☐Psychiatric Care
☐Hemophilia
☐Hepatitis A
☐Hepatitis B/C
☐Herpes
☐High Blood Pressure
☐High Cholesterol
☐Hives/Rash
☐Hypoglycemia
☐Irregular Heartbeat
☐Kidney Problems
☐Leukemia
☐Liver Disease
☐Low Blood Pressure
☐Lung Disease
☐Tonsillitis
☐Tuberculosis
☐Tumors/Growth
☐Ulcers
☐Venereal Disease
☐Radiation Treatment
☐Recent Weight Loss
☐Renal Dialysis
☐Rheumatic Fever
☐Rheumatism
☐Scarlet Fever
☐Shingles
☐Sickle Cell Disease
☐Sinus Trouble
☐Spina Bifida
☐Stomach Disease
☐Stroke
☐Swelling of Limbs
☐Thyroid Disease
☐Chest Pains
☐Cold Sores/Fever Blisters
☐Congenital Heart Disorder
☐Convulsions
☐Yellow Jaundice

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes: _____

Comment: _____

_____

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:

X _____

ADVANCED DENITISTRY OF CONNECTICUT

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

ADVANCED DENTISTRY OF CONNECTICUT

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Reza Radmand, D.M.D._____

Telephone: 203-375-1649_____ Fax: 203-377-5251_____

E-mail: info@radmanddental.com_____

Address: 2318 Main Street ; Stratford, CT 06615_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Advanced Dentistry of Connecticut

Financial Policy Agreement, Cancellation/No Show Policy, Assignment of Benefits, General Authorizations

Thank you for choosing Advanced Dentistry of Connecticut as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health.

Please read carefully and sign below. You may request a copy.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available through Care Credit and Lending Club Financing.

Cancellation & No Show Policy: Rescheduling must be given 48 hours before the appointment time. You may be rescheduled if you are more than 15 minutes late and you will be charged a $50 cancellation fee if you do not show for your scheduled appointment or if you cancel within 48 hours of your appointment. If you fail to keep more than 2 appointments without advance notification, you may be restricted to a walk in or time available basis.

Insurance Policy: As a courtesy to you, we will help you process all your 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. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.

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, your employer, and your insurance company. Our office is not a party to that contract.

At Advanced Dentistry of Connecticut we are 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 payments directly to Advanced Dentistry of Connecticut.

Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 30 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. On day 31 if insurance has not paid or if there is any remaining balance due, you will be held responsible to make a full payment or you will accrue finance charges. If at any point we receive a payment, or additional payment, from the insurance company, we will reimburse you with credit.

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.

Financial Charge Policy: As part of our new financial agreement, which will go into effect on March 1, 2016, a finance charge of 1.50% will begin to accrue on a monthly basis until payment is received in full. To avoid the finance charge, we kindly ask that you make payments within 30 days of service.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I authorize the following name(s) to have access to my dental information.

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Advanced Dentistry of Connecticut.

Patient/Guardian Signature: _____

Date: _____

Revised 1/18/16

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Advanced Dentistry of Connecticut

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 (01/01/2003), 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 a 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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.

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 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.

Contact Officer: Reza Radmand D.M.D.,

Telephone: 203-375-1649 Fax: 203-377-5251

E-mail: rradmand@gmail.com

Address: 2318 Main Street Stratford, CT 06615