Welcome to Brookhaven Family Dentistry

Dr. Andrew Kokabi

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Suite 102

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info@bfdentist.com

PATIENT INFORMATION & HEALTH HISTORY FORM

Name: _____
Last *First* *Middle*

Address: _____
Apt. # *City:* *State* *Zip*

Cell #: _____ How did you hear or who told you about us? _____
please be specific, we would like to thank them

Work/Home #: _____ Employer: _____ Occupation: _____

Email: _____ Marital Status: Divorced Single Married Widow
(Please circle)

Soc. Sec: _____ Birthday: _____ Sex: Male Female

Emergency Contact: _____ Relationship: _____ Phone: _____

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your initial 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.

DENTAL INFORMATION

	(Y)	(N)	Don't Know
Do your gums bleed when you brush?	☐	☐	☐
Ever had orthodontic treatment (braces)?	☐	☐	☐
Teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you have ear aches or neck pains?	☐	☐	☐
Had any periodontal (gum) treatments?	☐	☐	☐
Wear removable dental appliances?	☐	☐	☐
Had a serious/difficult problem associated with any previous dental treatment? If yes, explain:	☐	☐	☐

How would you describe your current dental problem?

Date of last dental exam:

What was done at that time:

Date of last dental xrays:

How do you feel about the appearance of your teeth:

MEDICAL INFORMATION

If you answer YES to any of the three items below, please stop & return this form to the receptionist

	(Y)	(N)	Don't Know
Have you ever had any of the following:			
Active Tuberculosis	☐	☐	☐
Persistant cough, longer than 3 weeks:	☐	☐	☐
Cough that produces blood:	☐	☐	☐
Are you in good health?	☐	☐	☐
Any changes in your general health in past year?	☐	☐	☐
Are you currently under the care of a physician?	☐	☐	☐
If yes, what are you being treated for?:			
Date of last physical exam:			
Physician:			
Name			
Phone			
Have you had any serious illness,operation, or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem?			

Please list all prescribed medications:

Over the counter (including vitamins/minerals/herbal:

	(Y)	(N)	Don't Know
Are you taking or have you taken any diet drugs such as Pondimin (fenflouramine), Redux (dexphenfluramine) or Phen-fen(fenfluramine-phentermine combination)?	☐	☐	☐
Do you drink alchoholic beverages?	☐	☐	☐
If yes, how much in the past 24 hours:			
Are you alcohol or drug dependent?	☐	☐	☐
If yes, have you receved treatment?	☐	☐	☐
Do you use drugs or other substances for recreational purposes? If yes, please list:	☐	☐	☐
Frequency:			
Do you use tobacco (smoking, sniff, chew)?	☐	☐	☐
Do you wear contact lenses?	☐	☐	☐

Are you allergic or had a reaction to:

	(Y)	(N)	Don't Know
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbituates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/ seasonal	☐	☐	☐
Animals	☐	☐	☐
Food (specify)	☐	☐	☐
Metals (specify)	☐	☐	☐
Other (specify)	☐	☐	☐

To YES responses, specify type of reaction:

	(Y)	(N)	Don't Know
Have you had an orthopedic joint replacement?	☐	☐	☐
If yes, when was operation done:			
If yes, have you had any complications with your prosthetic joint?	☐	☐	☐
Has a previous dentist or physician recommended that you take antibiotics prior to dental treatments?	☐	☐	☐
Name of doctor:			
Phone:			

WOMEN ONLY

Are you or could you be pregnant?	☐	☐	☐
Nursing?	☐	☐	☐
Taking birth control or homonal replacement?	☐	☐	☐

Please (x) to indicate if you have or have not had any of the following diseases or problems:

	(Y)	(N)	Don't Know
Abnormal bleeding	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion. If yes, date:	☐	☐	☐
Cancer / Chemotherapy/ Radiation treatment	☐	☐	☐
Cardiovascular Disease. If yes, specify below:	☐	☐	☐
___ Angina			
___Arteriosclerosis			
___Artificial heart valve			
___Congenital heart defects			
___Congestive heart failure			
___Coronary artery disease			
___Damaged heart valves			
___Heart attack			
___Heart murmur			
___High blood pressure			
___Low blood pressure			
___Mitral valve prolapse			
___Pacemaker			
___Rheumatic heart-disease/Rheumatic fever			
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Disease,drug or radiation-induced immunosuppression	☐	☐	☐
Diabetes (please specify)	☐	☐	☐
____Type I (insulin dependent) ___Type II			
Dry mouth	☐	☐	☐
Eating disorder (please specify)	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/ persistant heart burn	☐	☐	☐
Glaucoma	☐	☐	☐

	(Y)	(N)	Don't Know
Hemophilia	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Recurrent infections	☐	☐	☐
If yes, type of infection:			
Kidney problems	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify:			
Malnutrition	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:			
Osteoporosis	☐	☐	☐
Persistant swollen glands in neck	☐	☐	☐
Respiratory problems	☐	☐	☐
____Emphysema ____Bronchitis, etc			
Sever headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Sinus trouble	☐	☐	☐
Sleep disorder	☐	☐	☐
Sores or ulcers in mouth	☐	☐	☐
Stroke	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problem	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW?

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction, I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or ommissions that I may have made in the completion of this form.

Signature of patient / legal guardian

Date

Brookhaven
Family Dentistry

Informed Consent for General Dental Treatment

You have the right to be informed about your dental treatment so that you may make a decision to undergo dental treatment after knowing the risks and hazards. This disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so you may give your consent to have dental treatment.

Possible Complications and Facts Associated with Dental Treatment:

1. Medications: Certain medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

2. Dental restorations on front teeth will have a shorter life expectancy if they are not treated with care from the patient. If you bite into hard, crunchy, or sticky foods OR if you use your front teeth for abnormal purposes(ie; biting off a bottle cap or cutting fishing wire), there is a good chance your dental restoration will fail. Additionally, general health, good oral hygiene, regular dental check-ups, diet, etc. can affect longevity.

3. Extractions: If an extraction site is not treated with an implant or bridge, then the teeth adjacent to this site can shift and ultimately may need to be extracted.

4. Root Canal Treatment: Root canal treatment is an attempt to save a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth that has had root canal therapy may require retreatment, surgery, or even extraction.

5. It is the responsibility of the patient to seek attention from the dentist should any undue or unexpected problems occur. The patient must diligently follow any and all instructions. Failure to follow instructions can result in dental treatment and dental restorations failing.

6. Sensitivity of Teeth: Sometimes, after cleanings, deep cleanings, fillings, root canals, crowns, or other dental treatment, the teeth may exhibit sensitivity. It may be mild to severe. This sensitivity may last for a short period or a long period. If it is persistent, notify us since this sensitivity may be from some other source. There is a small chance that if the sensitivity does not go away, then the teeth may need root canals or other treatments.

7. With all dental treatments, there is a chance for the possible accidental swallowing or aspiration of tooth particles, dental instruments, or other foreign bodies. Surgery may be required to remove these objects from your body.

8. Local Anesthesia(getting your teeth numb): Certain possible risks that, although rare, could include pain, swelling, bruising, infection, nerve damage(which can lead to prolonged numbness of the lip, chin, gums or tongue which could feel numb and could remain for days, weeks or very rarely permanently), and unexpected allergic reactions which could result in heart attack or stroke.

9. It is very hard to get a filling or crown to exactly match the tooth or adjacent teeth. We will do our best and most times our patients are satisfied with the appearance of restorations, however it is impossible to get a dental restoration to 100% match the natural teeth because they are made of different materials than natural teeth.

10. Some dental treatment may result in bleeding. Bleeding, usually controllable, but may be prolonged and require additional care.

11. Dental Cleanings: Dental cleanings are very important. If excessive amounts of tartar accumulate on teeth, then periodontal disease will develop. Periodontal disease will result in loss of bone that can ultimately lead to loose teeth that may need to be extracted. Periodontal disease(not cavities) is the most common cause of tooth extractions.

I understand that dentistry is not an exact science and success with treatment cannot be guaranteed. I understand the statements listed above and have had any questions regarding them answered. I authorize Dr. Kokabi and/or such associates and assistants to render dental treatment and to use anesthetics and/or medications. I will follow all treatment and post treatment instructions as explained and directed to me.

Patient Name: _____
(please print)

Patient's Signature_____ Date: _____

Brookhaven
Family Dentistry

Practice Policy & Financial Agreement

In compliance with the TRUTH IN LENDING LAW, here is our practice policy and financial agreement.

Please sign below to acknowledge that you have read and understand the following information.

If you have dental insurance we will gladly process your claims for you. By signing below you authorize direct payment of dental benefits to Brookhaven Family Dentistry, PC.

We accept cash, check, Visa, Mastercard.

If your check is returned, there will be a returned check fee of $25.00 added to your account. All future payments will then be required in the form of cash or credit card only.

Our practice is committed to providing the best treatment for our patients and our fees are based on what is usual and customary for our area. Please understand that you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Our office uses Composite (tooth colored) fillings on many restorations. Some insurance companies do not cover, or cover at a reduced rate, these composite fillings on back teeth. If you are concerned your insurance may not cover the services being provided to you, please contact your insurance company prior to your appointment for a breakdown of their allowable benefits and let your doctor know if you would prefer a Silver(Mercury containing) restoration.

For dental procedures associated with dental codes D1110(Prophylaxis) & D0120(Periodic Oral Evaluation) we offer a 16% courtesy adjustment for payment prior to or at time of service. For the dental procedure associated with dental code D0274(Bitewings-Four Films) we offer a 48% courtesy adjustment for payment prior to or at time of service.

It is not our policy to double book our patients. The appointment, which you schedule, is set aside specifically for you. Please provide us with at least 24 hours notice in the event that you cannot keep your appointment. If this courtesy is not allowed, we reserve the right to charge a $25.00 missed appointment fee to your account.

I understand and agree to the above terms.

Signed: _____ Date: _____

Print Name: _____

Brookhaven

Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

☐ **I have received a copy of Brookhaven Family Dentistry's Notice of Privacy Practices.**

☐ **I have refused a copy of Brookhaven Family Dentistry'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):**

_____

_____

_____

Brookhaven Family Dentistry, P.C. 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 09/22/2013 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 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 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. With the exception of 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 a 12-month period, 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 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 (e-mail).

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.

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.

Our Privacy Official: Dr. Andrew Kokabi

Address: 3575 Durden Drive, Suite 102, Atlanta, GA 30319 Email:info@bfdentist.com