PeterAbas
DDS, INC.

Welcome to our Dental Office!

Patient Name (Last, First, MI) :_____Preferred Name:_____

Gender: M F Birthdate:____/_____/_____ DL#:_____ Social Security No: _____

If patient is a child, parent's full name:_____ Birthdate:____/____/_____SS#:_____

Residence Address:_____City, State, Zip:_____

Home Phone:_____ Cell Phone:_____ e-mail:_____

Employer:_____Occupation:_____

Work Address:_____ City, State, Zip:_____

Work Phone:_____

Spouse's Name (Last, First, MI):_____ Birthdate: _____/_____/_____

Spouse's SS#_____ Spouse's Phone:_____

Spouse's Employer:_____Work Address:_____

Person Responsible for Account:_____

Insurance Carrier:_____ Dental Plan No:_____

Secondary Insurance:_____Dental Plan No:_____

Emergency Contact Name:_____Emergency Contact Phone:_____

Whom may we thank for sending you to our office?_____

Dental History

Reason for this visit:_____

Previous Dentist_____Date last treated_____

Date of last complete series x-rays_____ Are you in pain at this time?(circle one) Yes / No

Have you noticed any loose teeth? Yes / No Does food tend to get caught between your teeth? Yes / No

Do you have any pain or swelling of your gums? Yes / No Do your gums tend to bleed? Yes / No

Have you had any problems with your jaw joint? Yes / No Do you feel nervous about dental treatment? Yes / No

Have you ever had an upsetting experience in a dental office? Yes / No

How do you feel about the appearance of your teeth?_____

Consent for Services

I do authorize and give consent to the doctor and his staff to administer treatment, including, but not limited to: local anesthetic, analgesia, and other such treatment which may be necessary for the above named patient. I also understand that the use of these agents and some procedures embodies a certain risk. I further acknowledge that the completed medical and dental histories were completed fully and to the best of my knowledge. As a condition of your treatment by this office, I understand that I am financially responsible for all services rendered. PLEASE NOTE PAYMENT IS EXPECTED FOR SERVICES RENDERED AT THE TIME OF THE FIRST VISIT. Patients who carry dental insurance understand that he or she is responsible for all charges not covered by dental insurance. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. Financial arrangements must be made in advance. I agree to pay the charges incurred for services rendered at the time of treatment unless I set up financial arrangements prior to treatment.

_____Date:_____ Relationship to Patient:_____

Signature of patient, parent or guardian

(949) 586-1127 | info@peterabasdds.com |
Taj Mahal Medical Center, 23521 Paseo De Valencia Suite 112, Laguna Hills, CA 92653, USA

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Cell Phone Number_____Email_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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, please explain: _____
Have you had any surgeries in the past 6 months**?** **Yes No** If yes, please explain: _____
Are you taking any medications, pills, or drugs? **Yes No** If yes, please list meds: _____
_____

Do you use tobacco? **Yes No**
Do you use controlled substances? **Yes No**
Do you need to pre-medicate for dental work? **Yes No** If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel? **Yes No** If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you **allergic** to any of the following?

Aspirin **Penicillin** **Codeine** **Acrylic** **Metal** **Latex** **Local Anesthetics**

Other If yes, please explain:_____

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

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

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

Comments: _____
_____
_____
_____

To the best of my knowledge, the questions on this 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 _____ DATE _____

PeterAbas
DDS, INC.

Financial Consent To Services

As a condition of treatment by Dr. Abas, financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are rendered *unless* prior financial arrangements have been made.

Patients with dental insurance understand that all dental services are charged directly to the patient and she/he is personally responsible for payment of all dental services. As a courtesy, Dr. Abas will help prepare the patient's insurance forms and will credit any insurance collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by your insurance company. Please understand that the insurance policy is a contract between the insurance company and you: we are not party to this contract. The patient remains responsible for the balance of the dental account regardless of your insurance.

For all accounts exceeding 60 days, a service charge of 1½% per month (18% per annum) on the unpaid balance may be charged unless written financial arrangements have been previously made.

An adult accompanying a minor and the parents/guardian to the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized.

I understand that a treatment plan estimate for dental care will be valid for 60 days from the date of the patient examination.

I agree to pay the charges incurred for services rendered at the time of treatment unless I set up financial arrangements prior to treatment.

In the event of legal action by either party for services rendered at Peter Abas, DDS, the prevailing party shall recover reasonable attorney's fees and costs. Any costs incurred in the collection of fees (such as agency fees) will be added to the account.

I grant permission to you or your assignee to telephone me to discuss this statement or my treatment.

Signature: Patient/Guardian: X _____ **Date:** _____

Print Name: _____

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Insurance Agreement

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. The range of benefits depends solely on what plan your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Many plans base the amount of benefit on a fee schedule arbitrarily set by the insurance company. For this reason, your actual benefit may be lower than the reimbursement percentage indicated in your dental plan. For example, if your plan states that they will pay 80% of the cost of a specific treatment, this means that your insurance carrier will pay 80% of their fee which is not necessarily the actual fee charged by our office.

Our billing department makes every effort on your behalf to obtain payment from your insurance carrier for our services. *It will be your responsibility to inform us of any changes to your status or type of coverage so we may better serve you.* Insurance status can change and if we are not notified before treatment is rendered, any payment becomes the patient's responsibility.

If your insurance company postpones payment for more than 90 days, we ask that you make the remaining payment while we work together to get the insurance company to pay the obligated amount.

If you do not have dental insurance or the service is not a covered benefit, payment is due at the time of service. For your convenience we accept cash, check, MasterCard, VISA, American Express and Discover. Other financial arrangements may be available and we would be happy to discuss them with you. Returned checks and balances older than 60 days may be subject to additional collection fees and interest of 1.5% per month.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. All insurance companies are not the same in what they consider to be usual and customary fees. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We recommend that you take the time to read over your policy and contact your carrier if you have any questions regarding your coverage.

Regarding Indemnity Insurance

Dr. Abas will process any insurance claims as a courtesy to our patients. *We will initially ask you for your estimated co-pay.* Please understand that this is only an estimate based upon the information available to us and we cannot guarantee that your insurance carrier will pay the "estimated" figure. The balance is your responsibility whether the insurance carrier pays or not. Therefore, the entire balance on an account remains the sole responsibility of the patient. Please keep in mind that your insurance policy is a contract between you and your insurance company, and that we are not party to that contract.

PeterAbas
DDS, INC.

Insurance Agreement

There may be instances when a procedure is not covered by your insurance. We urge you to call your insurance company should you have any questions regarding coverage before proceeding with treatment as you will be responsible for payment once treatment begins.

Regarding Insurance Plans where we are Participating as a Provider

All co-pays and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not participating as a provider, it is your responsibility to inform us of the policy change. If we are not notified before treatment begins, you will be responsibility for all charges.

I hereby authorize and assign my insurance company to pay Peter Abas, DDS, Inc. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.

I have read the Billing and Insurance Policy. I understand and agree to the terms of the Billing and Insurance Policy.

Signature: Patient/Guardian: X_____ **Date:** _____

Print Name: _____

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PeterAbas DDS, INC.

HIPAA Notice of Privacy Practices

Your information will be treated in the strictest confidence. See further information regarding the privacy of your records and HIPAA compliance.

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.

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 (03/02/2015), 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.

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 usually will not 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 your personal mobile device, or with someone who answers your phone if you are not home.

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 end 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 end 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 end 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 end 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 end 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 end 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 on 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 on this Notice.

We support your right to the privacy of your health information.

Contact: Peter Abas, DDS
Telephone: (949) 586-1127
Fax: (949) 586-1129
Email: peterabasdds@gmail.com

Address: 23521 Paseo De Valencia, Suite 112
Laguna Hills, CA 92653

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices.

Patient Signature :_____ Date:_____

Print Name:_____

PeterAbas
DDS, INC.

HIPAA Consent Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

- ☐ You may discuss my dental/medical records with:

- ☐ Please do not discuss my medical or payment information with anyone.

Date:_____

Patient Signature:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient:_____

Print Name_____

Source of
Authority_____

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