SERENITY DENTAL GROUP

Patient History Form

Patients First Name _____ **MI** ____ **Last Name** _____

ABOUT YOU

◯ Female ◯ Male

Todays date _____
E-mail address _____
I Prefer to be called _____
Birth date _____ Age ____ SS# _____
Address _____ Apt # _____
City _____ State _____ Zip _____
Phone-Home _____ Cell _____
Work phone _____ Ext.# _____
Employer _____
Address _____
Occupation _____
Where and when best times to reach you? _____

Referred by _____
Other family members seen by us _____
Previous dentist _____
Last visit date _____

ABOUT SPOUSE

Name-First _____ Last _____
Birth date _____ Age ____ SS# _____
Phone-Home _____ Cell _____
Phone-Work _____ Ext.# _____
Employer _____

WHO IS RESPONSIBLE FOR YOUR ACCOUNT

Name-First _____ Last _____
Relation _____
SS# _____ Driver's license # _____
Work phone _____ Ext.# _____
Cell phone _____
Employer _____

WHO SHOULD WE CONTACT IN AN EMERGENCY?

Name-First _____ Last _____
Relationship _____
Phone-Home _____ Cell _____

PRIMARY INSURANCE COVERAGE

Dental coverage? ◯ Yes ◯ No
Insurance name _____
Insurance address _____

Insurance phone _____
Group #, plan, local or policy # _____

Insureds name _____
Insureds relation to patient _____
Insureds birth date _____
Insureds subscriber ID _____
Insureds employer _____

SECONDARY INSURANCE COVERAGE

Dental coverage? ◯ Yes ◯ No
Insurance name _____
Insurance address _____

Insurance phone _____
Group #, plan, local or policy # _____

Insureds name _____
Insureds relation to patient _____
Insureds birth date _____
Insureds subscriber ID _____
Insureds employer _____

YOUR MEDICAL CARE

Do you have a personal physician?
◯ Yes ◯ No
Physician's name _____
Physician's phone _____
Date of last visit _____
Are you currently under the care of a physician? ◯ Yes ◯ No
If yes, please explain _____

Your current physical health is:
◉ Good ◯ Fair ◯ Poor

SERENITY DENTAL GROUP

Patient History Form

Patients First Name MI Last Name

WHY HAVE YOU COME TO THE DENTIST TODAY?

List reasons here: _____

HEALTH INFORMATION

Have you ever taken Fosamax, Actonel, Boniva, or any other biphosphonate? ◯ Yes ◯ No

Do you take prescription, over-the-counter, or herbal supplement drugs? ◯ Yes ◯ No

If YES, list each one: _____

FOR WOMEN

◯ Yes ◯ No Are you using a prescribed birth control method?

◯ Yes ◯ No Are you pregnant?

◯ Yes ◯ No Are you nursing?

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

◯ Yes ◯ No Abnormal Bleeding
◯ Yes ◯ No Alcohol/Drug Abuse
◯ Yes ◯ No Anemia
◯ Yes ◯ No Arthritis
◯ Yes ◯ No Artificial Bones, Joints, Valves
◯ Yes ◯ No Asthma
◯ Yes ◯ No Blood Transfusion
◯ Yes ◯ No Cancer, Chemotherapy
◯ Yes ◯ No Colitis
◯ Yes ◯ No Congenital Heart Defect
◯ Yes ◯ No Diabetes
◯ Yes ◯ No Difficulty Breathing
◯ Yes ◯ No Emphysema
◯ Yes ◯ No Epilepsy
◯ Yes ◯ No Fainting Spells
◯ Yes ◯ No Frequent Headaches
◯ Yes ◯ No Glaucoma
◯ Yes ◯ No Hay Fever
◯ Yes ◯ No Heart Attack
◯ Yes ◯ No Heart Murmur
◯ Yes ◯ No Heart Surgery
◯ Yes ◯ No Hemophilia
◯ Yes ◯ No Hepatitis
◯ Yes ◯ No Herpes, Fever Blisters
◯ Yes ◯ No High Blood Pressure
◯ Yes ◯ No HIV positive, AIDS
◯ Yes ◯ No Hospitalized for Any Reason
◯ Yes ◯ No Kidney Problems
◯ Yes ◯ No Liver Disease
◯ Yes ◯ No Low Blood Pressure
◯ Yes ◯ No Mitral Valve Prolapse
◯ Yes ◯ No Pacemaker
◯ Yes ◯ No Psychiatric Problems
◯ Yes ◯ No Radiation Treatments
◯ Yes ◯ No Rheumatic / Scarlet Fever
◯ Yes ◯ No Seizures
◯ Yes ◯ No Shingles
◯ Yes ◯ No Sickle Cell Disease / Traits
◯ Yes ◯ No Sinus Problems
◯ Yes ◯ No Stroke
◯ Yes ◯ No Thyroid Problems
◯ Yes ◯ No Tuberculosis (TB)
◯ Yes ◯ No Ulcers
◯ Yes ◯ No Venereal Disease

List any other serious medical conditions that you have ever had: _____

SERENITY DENTAL GROUP

Patient History Form

Patients First Name MI Last Name

SLEEP

◯ Yes ◯ No Do you snore while sleeping
◯ Yes ◯ No Have you been diagnosed/treated for sleep apnea?
◯ Yes ◯ No Do you use a CPAP or other appliance?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

◯ Yes ◯ No Aspirin
◯ Yes ◯ No Codeine
◯ Yes ◯ No Dental Anesthetics
◯ Yes ◯ No Erythromycin
◯ Yes ◯ No Jewelry
◯ Yes ◯ No Latex
◯ Yes ◯ No Metals
◯ Yes ◯ No Penicillin
◯ Yes ◯ No Tetracycline

List any other drugs or materials that you are allergic to: _____

◯ Yes ◯ No Have you ever had a serious or difficult problem associated with previous dental work?
◯ Yes ◯ No Do you require antibiotics before dental treatment?
◯ Yes ◯ No Are you currently in pain?
◯ Yes ◯ No Do your gums ever bleed?
◯ Yes ◯ No Do you like your smile?
◯ Yes ◯ No Would you like whiter teeth?
◯ Yes ◯ No Fresher Breath?
◯ Yes ◯ No Have you ever had pain or discomfort in your jaw joint?
◯ Yes ◯ No Do you smoke or use tobacco?

How many times a week do you floss?

_____

How many times a day do you brush?

_____

What type of tooth brush bristles:
◯ Soft ◯ Medium ◯ Hard

Your current dental health is:
◯ Good ◯ Fair ◯ Poor

Additional comments: _____

_____

_____

CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Payment is due at time of service unless prior arrangements have been made. I understand that I am responsible for payment of services rendered and also responsible of any copay and deductibles that my insurance does not cover.

Signature _____ Date _____

SERENITY DENTAL GROUP

TM / AIRWAY–SLEEP SCREENING FORM

Patient Name: _____ **Date:** _____

Patient Questionnaire:

1. Have you ever been told that you need to wear a CPAP for sleep?

   Yes ☐ No ☐

2. Do you use over-the-counter medication for headache pain or as a sleep aid?

   Yes ☐ No ☐

3. Is it easy for you to fall asleep?

   Yes ☐ No ☐

4. Do you wake up frequently during the night?

   Yes ☐ No ☐

5. Do you feel rested when you wake up in the morning?

   Yes ☐ No ☐

6. Do you experience popping, clicking, or other noises in your jaw joints?

   Yes ☐ No ☐

Patient Signature: _____ **Date:** _____

FOR CLINICAL OFFICE USE:

JVA Quick Completed: Yes ☐ No ☐

- BP: _____
- Open Bite: _____
- OB: _____ mm
- OJ: _____ mm

Range of Motion Measurements:

Interincisal Opening (without pain): ____mm

Interincisal Opening (with pain): _____ mm

Lateral Excursion – Right: ____mm

Lateral Excursion – Left: ____mm

Protrusive: ____mm

By (Initials): _____ Date: _____

OFFICE FINANCIAL POLICY

Serenity Dental Group
2510 Stevens Creek Blvd
Tel. (408) 999-0444 Fax (408) 999-0920

In our continued commitment to provide the highest quality dental care available to all of our patients, and to have those services comfortably affordable, we are pleased to offer the following payment options. Please check all that apply:

Payment Options

☐ Personal Credit Cards

☐ VISA ☐ Discover ☐ MasterCard ☐ American Express

☐ Prepayment – 5% discount (3% credit card) for services over $1,000 when prepaid in full

☐ CareCredit financing (please ask our administrative staff for details)

We are committed to supporting you in understanding your dental health so that you may make informed choices. As a courtesy, we will process your insurance benefits to help relieve you of this time-consuming task.

I agree that I am fully responsible for the total payment of all procedures performed in this office, including any treatment not covered by my dental insurance. I understand that all services are due and payable at the time services are rendered, regardless of insurance benefit status.

A finance charge of 1.5% per month (18% annually) will be applied to balances unpaid 60 days from the treatment date.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. Late arrivals may require rescheduling and may result in a $50 per appointment-hour rescheduling fee. There is no charge for appointment changes with at least 48 hours notice.

We are here to assist you. Please share any questions or concerns with our team.

Signature (Responsible Party): _____ **Date:** _____

Financial Coordinator: _____ **Date:** _____

Serenity Dental
Ali Heidari, D.D.S.
2510 Stevens Creek Blvd.
San Jose California 95128
Email: Info@SerenityDentistry.com
Call: (408) 999-0444

**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.

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

I acknowledge that I received a copy of Dr. Ali Heidari's Notice of Privacy Practices.

Patient name: _____

Signature: _____ Date: _____