PRITI NAIK DDS
family + cosmetic dentistry

All information provided is confidential

Patient Information

Full Name_____ Today's Date_____
Date of Birth_____ SSN#_____ Gender: *Male/Female*
Home Address_____ City_____ State_____ Zip_____
Phone (Home)_____ Work _____ Cell _____
Email Address_____
Preferred contact method? Home Phone____ Cell Phone____ Work Phone____ Email_____

Patient or Parent 's Employer_____ Occupation_____
Business Address _____ City_____ State_____ Zip_____
Spouse or Parent's Name_____ Spouse's SSN_____
Spouse's Employer_____

Referral Info:

How did you hear about our practice?
___Internet: Please Circle: *Google, Yahoo, Yelp, Angie's List, Website, Other*_____
___Insurance Company
___Yellow pages ___Friend/Family Member: if so, Name of Person_____ Other_____

Responsible Party

Person Responsible for this Account_____ Relationship to Patient_____
Address _____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Drivers License #_____
Birthdate_____ SSN#_____
Employer_____
Is this Person Currently a Patient in our Office? Yes____No_____

For your convenience, we offer the following method of payment. Please circle the option you prefer. Payment in full is due at each appointment: *Cash Personal Check Visa Mastercard Amex*

Insurance Information

Name of Insured _____ Relationship to Patient_____
Birthdate_____ SSN#_____ Date Employed_____
Name of Employer_____ Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group # _____ Policy/ID#_____
Ins. Co. Address _____ City_____ State_____ Zip_____
How much is your deductible?_____ Max Annual Benefit?_____

Do you have any additional insurance? Yes No If Yes, complete the following

Name of Insured _____ Relationship to Patient_____
Birthdate_____ SSN#_____ Date Employed_____
Name of Employer_____ Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group # _____ Policy/ID#_____
Ins. Co. Address_____ City_____ State_____ Zip_____
How much is your deductible?_____ Max Annual Benefit?_____

Over Please

PRITI NAIK DDS
family + cosmetic dentistry

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If Yes, please explain_____	☐	☐
3. Are you taking any medications including non-prescriptions? If yes, what?_____	☐	☐
4. Have you ever taken Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or other Anti-Biotics	☐	☐
Sulfa Drugs	☐	☐
Barbituates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury)	☐	☐
Latex Rubber	☐	☐
Other_____	☐	☐

10. Women Only:	Yes	No
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Dizziness	☐	☐	Frequently Tired	☐	☐	Tuberculosis/Lung Problems	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy/Chemo	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions/Seizure	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Heart Trouble	☐	☐	Joint Replacement or Implant	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Mitral Valve Problem	☐	☐	Sexually Transmitted Disease	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcer	☐	☐	Other_____	☐	☐
Bleeding Problems	☐	☐	Herpes	☐	☐	_____		

Patient Dental History

Name of Previous Dentist_____ Date of Last Exam_____

Previous Dentist's Location_____ Date of Last Cleaning_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are you teeth sensitive to hot/cold	☐	☐
3. Are your teeth sensitive to sweet or sour?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have sores or lumps in/near mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening/closing jaw	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind you teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding after extractions?	☐	☐
13. Have you had any orthodontic treatments?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement_____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____

Signature of patient (or parent if minor) Date

PRITI NAIK DDS
family + cosmetic dentistry

Financial Policy

In order to provide you with the highest quality dental care on a sound business basis, we provide our patients with estimates of fees. Patient, parent and/or guardian is responsible for the patient portion on the date of service. This is not your insurance company's responsibility. **We will file necessary claim to your insurance as a courtesy to you.** Our estimate is a guess based on the information provided by the insurance representative. The information given to us is not a guarantee of payment of approval for the treatment recommended by our dentist**.** All estimates are subject to final approval by your dental insurance plan. Therefore, the amount due is subject to change after final explanation of benefits have been paid. It is your responsibility to call your insurance company if they have not paid your claim within 45 days from the date of service. Any balance beyond 45 days is your responsibility, and interest will be applied to your account at a rate of 1.5% per month. We reserve the right to apply $20 rebilling fee, $25.00 late charges toward overdue financial agreements, and all returned checks are subject to a $25 fee. We have the option to report your balance with us to any credit reporting agency and credit bureau. In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees. _____ (Initials) I understand the above information

Financial options that we provide at this time:

*Cash or check on date of service *Major credit card (American Express, MasterCard, Visa)
*5% reduction on patient portion over 500.00 if paid prior to treatment with cash or check only
*10% Senior Citizen courtesy (age 65 and over) *Extended payment plan (based on credit approval)

It is your responsibility to complete treatment and follow recommended maintenance schedule. If the treatment and maintenance plans are not followed and/or appointments are missed, adverse results could affect your dental health. If you do not proceed with your treatment plan in a timely manner, further treatment for the involved teeth, supporting tissues, adjacent and opposing teeth, muscles or joints can be affected. _____(Initials) I understand the above information

Insurance Policy

Importance of patient awareness regarding insurance benefits:

Our office realizes how important insurance benefits are. We ask that you carefully review your policy and/or contact your insurance carrier so you are aware of benefits, frequencies, limitations, and/or restrictions. Please be informed that dental insurance is a contract between you and your insurance company. While our office is pleased to assist you with filing your claims, the primary focus of our office is providing the highest quality of care for you and your family regardless of insurance frequencies, limitations and/or restrictions. Please be aware that your insurance may have a yearly allowance (maximum) and anything over that amount will be your responsibility. If you have two insurance policies, please be aware that our office will provide you with the treatment information that you can file your second insurance. Your insurance mails a copy of an explanation of Benefits (EOBs) to you. Please pay attention to these statements. Check your policy to see if you have a dental deductible, and if your insurance pays at a percentage or by their allowed fee schedule. Please provide us with a copy of your insurance card and benefit booklet (if available) at your first visit or at the time of dental coverage changes. **It is your responsibility to provide us with any future changes in your insurance.** If any dental services have been provided with any other provider within the existing benefit year, please advise us. _____ (Initials) I understand the above information.

Appointment Commitment

Please review the following:
If circumstances occur and it is necessary to change your schedules appointment, we request that you give us at least 24 hours notice. There will be fee of $45.00/perhalf an hour depending on the length of the missed appointment. _____ (Initials) I understand the above information

I understand and agree to the aforementioned, and I promise to pay any/all remaining balance on my account.

X_____ Date:_____
Signature of patient, parent of guardian

PRITI NAIK DDS
family + cosmetic dentistry

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 November 1, 2008, 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 of 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 us in qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training 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 without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Marketing Health-Related Services: We will not use your health information for marketing communications.

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 $0.15 , for each page, $15.00 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 3 years, but not before November 1, 2008. 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.

CONTACT INFORMATION: Priti Naik, DDS, 8230 Boone Blvd #320, Vienna, VA 22182, 703-288-1800

PRITI NAIK DDS
family + cosmetic dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this Form

I have read and 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 (specify)

HIPPA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

This form is used to obtain acknowledgement of our notice of Privacy Practices or to document our good faith to obtain that acknowledgement.

Notice of privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient after April 14, 2003. We must make 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. Therefore, we must distribute the Notice to each new patient at the time of service and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.