Anoosh Afifi, M.S., D.D.S.

PATIENT INFORMATION (CONFIDENTIAL)

PATIENT: ______________________________ Email Address: ____________________

Last First MI

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Address: ______________________ City ______________ State ____ Zip ________

Birth date: ______ / ______ / ______ Social Security #: ______________________

Occupation ______________ **whom may we thank for referring you?** ______________

If college student, Full time ☐ Part time ☐ School ______________ City ______________ State ____

Patient's or Parent's Employer ______________________ Work Phone: ______________

Business Address ______________________ City ______________ State ____

Spouse or Parent's Name: ______________ Employer ______________ Work Phone ______________

In case of emergency whom should we contact? Please provide two names.

Name: ______________________ Name: ______________________

Phone: ______________________ Phone: ______________________

PERSON RESPONSIBLE FOR ACCOUNT: ______________________________

Last First MI

Home Phone: ______________ Work: ______________ Ext ____ Cell: ______________

Address: ______________________ City ______________ State ____ Zip ________

SS#: ______________ Employer ______________________ Work Phone: ______________

Is this person currently a patient in our office? Yes ☐ No ☐

PRIMARY DENTAL COVERAGE:

Insurance Co. Name: ______________________

Employer ______________________

Group, Union or local #: ______________________

Address: ______________________

City ______________ State ____ Zip ________

Phone: ______________________

Employee/Subscriber: ______________________

ID/SS#: ______________ DOB ______________

SECONDARY DENTAL COVERAGE:

Insurance Co. Name: ______________________

Employer ______________________

Group, union or local # ______________________

Address: ______________________

City ______________ State ____ Zip ________

Phone: ______________________

Employee/Subscriber: ______________________

ID/SS#: ______________ DOB ______________

ASSIGNMENT & RELEASE: I authorize the dentist or insurance company to release any information required for payment or review of this claim. I hereby authorize my insurance benefits to be paid directly to the dentist and I understand that I am financially responsible for all charges regardless of insurance payments.

____

Patient Printed Name

______________________________ Date: ______________

Signature of Patient/Parent

HEALTH HISTORY

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

1) **Yes** **No** Is your general health good?
2) **Yes** **No** Has there been a change in your health within the last year?
3) **Yes** **No** Have you been hospitalized or had a serious illness in the last three years?
No If **yes**, why? ______
4) **Yes** **No** Are you being treated by a physician now? For what?
No Date of last medical exam? ______ Date of last dental exam? ______
5) **Yes** **No** Have you had problems with prior dental treatment?
6) **Yes** **No** Are you in pain now?

II. HAVE YOU EXPERIENCED:

7) **Yes** **No** Chest pain (angina)?
8) **Yes** **No** Swollen ankles?
9) **Yes** **No** Shortness of breath?
10) **Yes** **No** Recent weight loss, fever, night sweats?
11) **Yes** **No** Persistent cough, coughing up blood?
12) **Yes** **No** Bleeding problems, bruising easily?
13) **Yes** **No** Sinus problems?
14) **Yes** **No** Difficulty swallowing?
15) **Yes** **No** Diarrhea, constipation, blood in stools?
16) **Yes** **No** Frequent vomiting, nausea?
17) **Yes** **No** Difficulty urinating, blood in urine?
18) **Yes** **No** Dizziness?
19) **Yes** **No** Ringing in ears?
20) **Yes** **No** Headaches?
21) **Yes** **No** Fainting spells?
22) **Yes** **No** Blurred vision?
23) **Yes** **No** Seizures?
24) **Yes** **No** Excessive thirst?
25) **Yes** **No** Frequent urination?
26) **Yes** **No** Dry mouth?
27) **Yes** **No** Juandice?
28) **Yes** **No** Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29) **Yes** **No** Heart disease?
30) **Yes** **No** Heart attack, heart defects?
31) **Yes** **No** Heart murmurs?
32) **Yes** **No** Rheumatic fever?
33) **Yes** **No** Stroke, hardening of arteries?
34) **Yes** **No** High blood pressure?
35) **Yes** **No** Asthma, TB, emphysema, other lung diseases?
36) **Yes** **No** Hepatitis, other liver diseases?
37) **Yes** **No** Stomach problems, uclers?
38) **Yes** **No** Allergies to: drugs, foods, medications, latex?
39) **Yes** **No** Family history of diabetes, heart problems, tumors?
40) **Yes** **No** AIDS?
41) **Yes** **No** Tumors, cancer?
42) **Yes** **No** Arthritis, Rheumatism?
43) **Yes** **No** Eye diseases?
44) **Yes** **No** Skin diseases?
45) **Yes** **No** Anemia?
46) **Yes** **No** VD, syphilis or gonorrhea?
47) **Yes** **No** Herpes?
48) **Yes** **No** Kidney, bladder disease?
49) **Yes** **No** Thyroid, adrenal disease?
50) **Yes** **No** Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51) **Yes** **No** Psychiatric care?
52) **Yes** **No** Radiation treatments?
53) **Yes** **No** Chemotherapy?
54) **Yes** **No** Prosthetic heart value?
55) **Yes** **No** Artificial joint?
56) **Yes** **No** Breast Implants?
57) **Yes** **No** Hospitalization?
58) **Yes** **No** Blood transfusions?
59) **Yes** **No** Surgeries?
60) **Yes** **No** Pacemaker?
61) **Yes** **No** Contact lenses?

V. ARE YOU TAKING:

61) **Yes** **No** Recreational drugs?
62) **Yes** **No** Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
63) **Yes** **No** Tobacco in any form?
64) **Yes** **No** Alcohol?

Please list: ______

______

VI. WOMEN ONLY:

65) **Yes** **No** Are you or could you be pregnant or nursing?
66) **Yes** **No** Taking birth control pills?

VII. ALL PATIENTS:

67) **Yes** **No** Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain: ______

______

I ______ certify that the above information is true and correct.

PATIENT/PARENT SIGNATURE: ______ **Date**______ **Dr. Initials**______

Anoosh Afifi, M.S., D.D.S.
600 Broadway, Suite 500
Seattle, WA 98122
206-323-9000

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I am aware of the Statement of Privacy Practices for the office of Anoosh Afifi, M.S., D.D.S. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. A copy of the Statement of Privacy Practices is also available upon request.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY	☐ YES	☐ NO
SPOUSE ONLY	☐ YES	☐ NO
OTHER (*PLEASE SPECIFY*): ____________________	☐ YES	☐ NO

____
Name of Patient or Personal Representative

____
Signature of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained

PROVIDED PRIOR TO TREATMENT? ☐ YES ☐ NO

DATE PROVIDED and STAFF INITIALS: ____________________

REASON FOR DENIAL:
- ☐ NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES
- ☐ WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING
- ☐ UNABLE TO SIGN
- ☐ REASON NOT GIVEN
- ☐ OTHER (*EXPLAIN*): ____________________

STATEMENT OF PRIVACY PRACTICES

Anoosh Afifi, M.S., D.D.S.
600 Broadway, Suite 500
Seattle, WA 98122
206-323-9000

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Personal Health Information

We will only request personal information needed to provide our standard of quality healthcare, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Personal Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Heath and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Anoosh Afifi, M.S., D.D.S.