LA PERIODONTICS & IMPLANT SPECIALISTS

Patient Registration

Patient Information

Patient Name: _____

Preferred Name: _____SSN: _____ Birthdate: _____

E-mail: _____ Family Status: Single Married Child Other

Phone: _____ _____ _____ _____
Mobile Home Work Other

Home Address: _____

_____

The person filling out this form is the: ☐ Patient ☐ Full POA or Medical POA ☐ Financial POA ☐ Other

PRIMARY RESPONSIBLE PARTY / MEDICAL POWER OF ATTORNEY (IF APPLICABLE)

Name: _____ Relation to the Patient _____

Birthdate: _____ E-mail: _____

Phone: _____ _____ _____ _____
Mobile Home Work Other

Home Address: _____

_____

Employment Information

Employer Name: _____ Phone: _____

Employer Address: _____
Address City State Zip Code

In an emergency who should be notified?

_____
Name Relationship Phone Number

Dr. Rana Shahi, DDS, MS, MSD
11859 Wilshire Blvd | Suite 550 | Los Angeles, CA 90025
Phone: 310-473-3800 | Fax: 310-473-9107

LA PERIODONTICS & IMPLANT SPECIALISTS

Primary Dental Insurance

Name of Subscriber: _____
Last First MI

Insured's Birth Date: _____ ID#:_____ Group#: _____

Insured's SSN#:_____ Insurance Plan Name: _____

Insurance Company Phone Number: _____

Insured's Address: _____
Street Address City State Zip Code

Relationship to Insured (circle): Self Spouse Child Other: _____

Secondary Dental Insurance (If applicable)

Name of Subscriber: _____
Last First MI

Insured's Birth Date: _____ ID#:_____ Group#:_____

Insured's SSN#:_____ Insurance Plan Name: _____

Insurance Company Phone Number: _____

Insured's Address: _____
Street Address City State Zip Code

Relationship to Insured (circle): Self Spouse Child Other: _____

Whom may we thank for referring you to our practice?

_____

General Dentist Name and Phone Number:

_____
Name Phone Number

Date of most recent dental exam and/or x-rays:

_____

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LA PERIODONTICS & IMPLANT SPECIALISTS

Consent for Periodontal Services

I, the patient, legal guardian, or healthcare surrogate, if any, hereby authorize and request LA Periodontics & Implant Specialists to perform all periodontal therapy and surgery indicated in the dental records and to complete whatever procedures are deemed advisable and necessary by the judgment of the doctor(s). By signing below, I acknowledge that as the patient or responsible party, I will discuss any aspect of my treatment I do not understand with my periodontist. I acknowledge that the benefits and risks of periodontal therapy are understood prior to accepting treatment. I also authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the doctor(s) at LA Periodontics & Implant Specialists. It has been explained to me, and I understand, that results are not, and cannot be, guaranteed or warranted. I grant my permission to LA Periodontics & Implant Specialists, to contact me at home or at my work via email, text, or phone to discuss matters related to my treatment. I have read the above conditions of treatment and agree to their content.

_____ _____ _____

Printed Name Signature Date

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment. All accounts are due and payable at the time of service rendered, unless prior arrangements have been made. If it is desired to extend payments for more than 30 days, specific arrangements must be made with our office. These extended payment courtesies are made at no interest or finance charge provided payments are received as promised. I understand that the fee estimate listed for this dental care can only be extended for a period of 12 months from the date of the patient examination. A service charge of 1.5% per month (18% annually) on the unpaid balance will be charged on all accounts exceeding 60 days and may be referred to a collection agency or an attorney, unless previously written financial arrangements are satisfied. Additionally, in the event any unpaid account balance is referred to an attorney for collection by the dentist or a collection agency, I agree to be responsible for all costs and reasonable attorneys' fees incurred in connection therewith. I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures, and/or diagnostic methods provided to me. I grant my permission for LA Periodontics & Implant Specialists, or any collection agency or attorney to whom an unpaid account balance has been assigned or referred to contact me via email, text, or phone to discuss this statement or any outstanding balances with this office.

_____ _____ _____

Printed Name Signature Date

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Insurance Disclaimer:

To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient. As a courtesy, our office will prepare and submit the necessary forms or reports to help you obtain your benefits from insurance companies, provided that the policy covers out-of-network benefits. LA Periodontics & Implant Specialists cannot guarantee payment of benefits from dental insurance. By signing below, I acknowledge that LA Periodontics & Implant Specialists is an out-of-network and non-contracted dentist and consent to submission of any necessary information including dental records on my behalf for claim(s) to my dental insurance plan.

_____	_____	_____
Printed Name	Signature	Date

Appointment Cancellation Policy

We understand that unforeseen events may arise, and you may need to cancel or reschedule your appointment. Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient cancels last minute or does not show for a scheduled appointment, another patient loses an opportunity to be seen. If we are not given notification for a cancellation or you do not make it to your appointment, you will be subject to:

For Non-Surgical Visits: A $75 fee will be charged per scheduled hour if the appointment is cancelled or rescheduled in less than **48 business** hours.

For Surgical Visits: A $300 fee will be charged if the appointment is cancelled or rescheduled in less than **48 business hours**.

By signing below, I acknowledge this office's appointment cancellation policy.

_____	_____	_____
Printed Name	Signature	Date

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LA PERIODONTICS & IMPLANT SPECIALISTS

HIPAA Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. I acknowledge that by signing this consent, I authorize LA Periodontics & Implant Specialists to use and/or disclose my protected health information to carry out day to day operations and treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that I have the right to inspect or copy the protected health information described by this authorization. I understand that at any time, I may submit a written revocation to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. I understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____	_____	_____
Printed Name	Signature	Date

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Patient Medical & Dental History

Patient Name:_____ Date_____

Indicate which of the following conditions/allergies you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ A-Fib
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Artificial Joints
- ☐ Artificial valves
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Condition
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Bisphosphonates
- ☐ Cancer
- ☐ Chemo/Radiation
- ☐ Cholesterol
- ☐ Circulatory Problems
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ GERD
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Arrhythmia
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes (Oral/Genital)
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pre-Medication
- ☐ Psych Care
- ☐ Respiratory Problems
- ☐ Rheumatoid Arthritis
- ☐ Seizure
- ☐ Sinus Problems
- ☐ STD
- ☐ Stomach Problems
- ☐ Thyroid Condition
- ☐ TMJ/TMD
- ☐ Tobacco Use
- ☐ Tonsilitis
- ☐ Tumors
- ☐ Ulcers
- ☐ Vertigo
- ☐ Other

If you listed **Other**, please specify: _____

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ATTENTION:

Please check the following list of medications, if you are using any please circle. If you are NOT taking any of the below medications, please circle None and initial below with today's date.

Agent	Brand Name
Etidronate	Didronel
Clodronate	Bonefos, Loron
Tiludronate	Skelid
Pamidronate	APD, Aredia
Neridronate	Olpadronate
Alendronate	Fosamax
Ibandronate	Boniva
Risendronate	Actonel or Atelvia
Zoledronate	Zometa or Reclast
Estrogen	Multiple Brand
Calcitonin	Fortical or Miacalcin
Denosumab	Prolia™

NONE

If you circled any of the medications above, please list the date last taken

_____
_____
_____

Signature: _____ Date: _____

Please list any **Allergies:** _____

Please circle any of the following that apply:

Estimate of your general health:

Excellent Good Fair Poor

Recently hospitalized (illness or injury): Yes / No

Presently being treated for any other illness: Yes / No

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FEMALE: Are you taking birth control pills? Yes / No

Currently pregnant and/or breast feeding? Yes / No

Do you smoke or use tobacco? Yes / No

Do you drink alcohol? Yes / No

Do you take aspirin regularly? Yes / No

Name of your primary care physician or medical practitioner and their phone number:

_____

Name Number

Please describe any current medical treatment, impending surgery, or other treatment.

_____
_____
_____
_____

List all medications (prescription and non-prescription) including regular doses of aspirin:

_____
_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____
_____
_____

Preferred Pharmacy:

Name: _____

Address: _____

Phone number: _____

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I routinely see my dentist every (please circle one):

3 months 4 months 6 months 12 months Not routinely

What is your immediate concern?

_____
_____
_____
_____

Check all that apply:

- ☐ Had dental complications and/or traumatic experiences
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you ever experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

If any of the checked boxes needs further explanation, please describe:

_____
_____
_____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

_____ _____ _____
Printed Name Signature Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you can access this information. Your privacy is important to us. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- To Your Family and Friends: 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. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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In some limited situations, the law allows or requires us to use/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 healthcare operations Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

LA PERIODONTICS & IMPLANT SPECIALISTS

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 27, 2014, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S. Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights

200 Independence Avenue, S.W.

Washington D.C. 20201

(202) 619-0257 Toll Free: 1-877-696-6775