ITANI DENTAL
SAN FRANCISCO

Patient Contact Information

Name:_____ DOB:_____ Age:_____ SSN:_____ ☐ Male ☐Female

Home #:_____ Business #:_____ Cell #:_____ E-mail:_____

Address:_____ City:_____ State:_____ Zip:_____

Employer: _____ Occupation: _____

Height: _____ Weight:_____ ☐ Single ☐ Married ☐ Domestic Partner

Spouse/Partner Name:_____ Occupation:_____ Phone #:_____

Guardian's Name:_____ Relation:_____ Phone #:_____

Address:_____ City:_____ State:_____ Zip:_____

Emergency Contact: *(Not living with you):* Name:_____ Relation:_____

Home #:_____ Business #:_____ Cell #:_____

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

Person responsible for payment of this billing account: ☐Self ☐Other

Name:_____ Home #:_____ Business #:_____

Address:_____ City:_____ State:_____ Zip:_____

Dental Insurance Information

Primary Dental Carrier:_____ Secondary Dental Carrier:_____

Address:_____ Address:_____

City, State, Zip:_____ City, State, Zip:_____

Phone #:_____ Group #:_____ Phone #:_____ Group #:_____

Policy Holder's Name:_____ Policy Holder's Name:_____

Relation:_____ Employer:_____ Relation:_____ Employer:_____

SSN/Member ID:_____ DOB:_____ SSN/Member ID:_____ DOB:_____

As dental care providers, we want to emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges and payments are your responsibility from the date that services are rendered. We encourage you to read and understand your particular dental policy.

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

Medical Insurance *(for Hospital Patients)*:

Carrier Name:_____ Group #:_____ Phone #:_____

Insured's Name:_____ SS#:_____ DOB:_____

Patient Health History

1. Have you been under the care of a physician in the past 2 years? Yes_____ No_____
   If yes, for what reason?_____
   Physician name: _____ Phone:_____
   Address:_____City:_____ State:_____ Zip:_____

2. Are you currently taking any medications? Yes_____ No_____
   If yes, please list name, dosage & medical condition: _____
   _____

3. Have you ever had an allergic reaction to any medications? Yes_____ No_____
   If yes, please list medication & effects:_____
   _____

   Are you taking anticoagulant medications? (Coumadin, Warfarin, Plavix, Ticlid, Heparin) Yes _____ No _____
   If yes, name of medication? _____ How long taken? _____

   Are you taking or have you ever taken bisphosponate drugs? (Such as Fosamax, Zometa, Boniva, Actonel, Didronel, Aredia, Skelid) Yes _____ No _____

   If yes, medication name? _____ I.V. 0ral? How long taken? _____

4. Women, please answer the following additional questions:
   Are you pregnant? Yes_____ No_____ Nursing? Yes_____ No____Taking birth control pills? Yes____ No____

5. Do you have or have you ever had any of the following:

AIDS:	Yes_____	No_____	Heart Murmur:	Yes_____	No_____
Alcohol Abuse:	Yes_____	No_____	Hemophilia:	Yes_____	No_____
Anemia:	Yes_____	No_____	Hepatitis (A, B, C):	Yes_____	No_____
Arthritis/Rheumatism:	Yes_____	No_____	Herpes:	Yes_____	No_____
Artificial (Joints, Limbs):	Yes_____	No_____	High Blood Pressure:	Yes_____	No_____
Asthma:	Yes_____	No_____	HIV:	Yes_____	No_____
Blood transfusion:	Yes_____	No_____	Jaundice:	Yes_____	No_____
Cancer, Tumors:	Yes_____	No_____	Kidney disease:	Yes_____	No_____
Chemo/Radiation:	Yes_____	No_____	Latex Sensitivity:	Yes_____	No_____
Chest Pain:	Yes_____	No_____	Liver disease:	Yes_____	No_____
Convulsions/Epilepsy:	Yes_____	No_____	Mitral Valve Prolapse:	Yes_____	No_____
Diabetes:	Yes_____	No_____	Pacemaker:	Yes_____	No_____
Dizziness/Fainting:	Yes_____	No_____	Psychiatric Care:	Yes_____	No_____
Drug Abuse:	Yes_____	No_____	Rheumatic Fever:	Yes_____	No_____
Emphysema:	Yes_____	No_____	Stroke:	Yes_____	No_____
Glaucoma:	Yes_____	No_____	Thyroid (Hypo/Hyper):	Yes_____	No_____
Headaches, Migraines:	Yes_____	No_____	Tuberculosis:	Yes_____	No_____
Heart Attack:	Yes_____	No_____	Ulcers:	Yes_____	No_____
Heart Disease:	Yes_____	No_____	Venereal disease:	Yes_____	No_____
Heart Surgery:	Yes_____	No_____			

Do you have or have you had any disease, condition or problem not on this list? If yes, please describe:
_____

I understand that the information gathered on this medical history form is intended to help inform the Itani Dental Group staff of any pre-existing medical conditions so that the best course of treatment can be determined. I understand that failure to disclose this information could affect my own safety. I affirm that the medical information indicated here is accurate and complete.

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

Health History Updates

Date:_____Change:_____Initial:_____
Date:_____Change:_____Initial:_____
Date:_____Change:_____Initial:_____

Dental History

1. On a scale from 1-10 (10 being highest):
   a. Where do you rate your dental health now? 1 2 3 4 5 6 7 8 9 10
   b. Where would you like your dental health to be in 5 years? 1 2 3 4 5 6 7 8 9 10
2. Are you satisfied with your smile? Yes_____ No_____
3. Have any of your friends or family had cosmetic dentistry? Yes_____ No_____
4. Do you plan to have cosmetic dentistry in the future? Yes_____ No_____
5. If so, which procedure would you have first? *(Choose one)*
   ☐ Whitening ☐ Straightening ☐ Porcelain Veneers
6. Are you inquiring about having all dental care done under General Anesthesia or I.V. Sedation? Yes__ No_____
7. Have you previously had dental care using any of the following types of sedation? *(Check all that apply)*
   ☐ Nitrous Oxide ☐ Oral Medication ☐ I.V. Sedation ☐ General Anesthesia
   At which dental office did you have treatment under sedation?_____
8. What is the reason for your visit today?_____
   _____
   _____
9. What is the date of your last dental visit?_____Dental Cleaning?_____X-rays?_____
10. Have you ever had any unsatisfactory experiences with previous dental treatment or providers? Yes__No_____
    Describe:_____
    _____
    _____
11. Have you ever been treated for periodontal (gum) disease? Yes_____ No_____
12. Have you ever had orthodontic therapy or worn braces? Yes_____ No_____
13. Do you clench or grind your teeth? Yes_____ No_____
14. Do you smoke a pipe, cigars, cigarettes or chew tobacco? *Circle appropriate product(s)* Yes_____ No_____
15. Do you have:

Bleeding, sore gums:	Yes_____ No_____	Unpleasant taste/breath:	Yes_____ No_____
Loose teeth:	Yes_____ No_____	Clicking Jaw:	Yes_____ No_____
Burning tongue/lips:	Yes_____ No_____	Locking Jaw:	Yes_____ No_____
Sensitivity to hot/cold:	Yes_____ No_____	Shifting of teeth:	Yes_____ No_____
Sensitivity to sweets:	Yes_____ No_____	Change in bite:	Yes_____ No_____
Sensitivity to biting/chewing:	Yes_____ No_____	Food impaction:	Yes_____ No_____

16. How often do you: Brush_____x's/day Floss_____x's/day or week
17. Do you use a **standard** or **electric** toothbrush? Standard_____ Electric_____
18. Do you use a fluoride or plaque rinse? Yes____ No____ Type/Brand? _____

Dental Anxiety Scale

Please answer the following questions by circling the appropriate response.

1. ***If you had to go to the dentist tomorrow, how would you feel about it?***
   a. Relaxed.
   b. A little uneasy.
   c. Tense/Anxious.
   d. So anxious that I sometimes break out in a sweat or almost feel physically sick.
   e. I start thinking of ways to cancel the appointment or not show up.

2. ***When you are waiting in the dentist's office for your turn in the chair, how do you feel about it?***
   a. Relaxed.
   b. A little uneasy.
   c. Anxious/Tense.
   d. So anxious that I sometimes break out in a sweat or almost feel physically sick.

3. ***When you are in the chair waiting while the dentist prepares to give you an injection, how do you feel?***
   a. Relaxed.
   b. A little uneasy.
   c. Anxious/Tense.
   d. So anxious that I sometimes break out in a sweat or almost feel physically sick.

4. ***When you are in the chair waiting while the dentist gets the drill ready to begin working on your teeth, how do you feel?***
   a. Relaxed.
   b. A little uneasy.
   c. Anxious/Tense.
   d. So anxious that I sometimes break out in a sweat or almost feel physically sick.

5. ***When you are waiting in the chair while the hygienist is getting out the instruments to scrape your teeth around the gums, how do you feel?***
   a. Relaxed.
   b. A little uneasy.
   c. Anxious/Tense.
   d. So anxious that I sometimes break out in a sweat or almost feel physically sick.

6. ***Please rate from 1-7 (1 being most fearful) the following fear-producing stimuli.***

	Most Fearful						Less Fearful
a. Needle for Injection	1	2	3	4	5	6	7
b. Noise of Drill	1	2	3	4	5	6	7
c. Pain of the procedure	1	2	3	4	5	6	7
d. Smell of teeth being drilled	1	2	3	4	5	6	7
e. Choking/gagging/blocking airway	1	2	3	4	5	6	7
f. Position of the chair being tilted back	1	2	3	4	5	6	7

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 **April 14, 2003**, 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 by 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 or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training 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 use 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 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 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

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 $0.00 for each page, $25 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 instance 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 6 years, but not before April 14, 2003. 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Samer Itani, DDS**

Telephone: **(415) 685-0011** Fax: **(415) 685-0010**

E-mail: **mail@itanidental.com**

Address: **450 Sutter St. Suite 2318, San Francisco, CA 94108**

Itani Dental, Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have 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 acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____

Itani Dental Inc.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION I: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Samer Itani, DDS

Telephone: (415) 685-0011 Fax: (415) 685-0010

E-mail: mail@itanidental.com

Address: 450 Sutter Street, Suite 2318, San Francisco, CA 94108

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.

Signature:_____ Date:_____

**If this Consent is signed by a personal representative on behalf of the patient, complete the following:*

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

ITANI DENTAL
SAN FRANCISCO

Financial and Insurance Policy

Payment for Services:

Payment is due at the time services are rendered. For certain types of treatment, such as procedures involving sedation or anesthesia, payment may be required in advance. We accept cash, Visa, MasterCard, American Express, online, money order, and personal check payments.

If You Have Insurance:

If you have dental insurance, we will be glad to help you bill your insurance for our services. Keep in mind though, that your insurance contract is a contract between you, the insurance company, and, if it is provided by an employer, your employer.

- As a courtesy, we will submit a claim to your insurance carrier on your behalf based upon the insurance information you provide to us before or at the time of your appointment. It is your responsibility to give us correct and complete insurance and necessary personal information and to inform us of any changes to your insurance.
- Your insurance may pay all, part, or none of the charges for your treatment depending on the terms of your contract. Prior to your treatment, we will prepare or seek from the insurance company an estimate of your costs based upon the insurance information we have. Remember, however, it is only an estimate and you are responsible for any charges not covered by your insurance at the time of final payment by the insurance company.
- Please contact your insurance company for answers to specific questions regarding your coverage and their payment policies and reimbursement procedures.

Please Note:
There is a $40.00 fee if your check is returned to our office unpaid by your financial institution.
Outstanding balances over 60 days are subject to collections fees and an interest rate charge of 18% APR.

I certify that I have read, understood, and received a copy of the above Financial/Insurance Policy. I understand my financial responsibility for dental treatment.

Patient's Name: _____ Date: _____

Patient /Guardian Signature: _____

ITANI DENTAL
SAN FRANCISCO

Cancellation and Missed Appointment Policy

So that we may best accommodate your and other patients' appointment and emergency requirements, it is necessary that we apply a fee for late cancellations or missed appointments. A failure to give timely notice of a cancellation means that we cannot give that time to another patient and reduces our ability to meet all patients' needs.

Unforeseeable emergencies will be taken into consideration if a cancellation fee is assessed.

I. General Appointments:

Any appointment requires two business days in advance (Monday – Friday) for cancellations and/or rescheduling.

The late cancellation fee for a general appointment is $100.00 per hour for each hour allotted for the appointment.

II. I.V. Sedation and General Anesthesia Appointments:

Appointments under sedation require 10 business days in advance (Monday – Friday) for cancellations/rescheduling once the surgery treatment date is scheduled. These appointments include I.V. sedation, and hospital cases. Because of their complexity and the number of parties involved, these cases require considerable time to schedule. Therefore, the appointment can only be cancelled without penalty in the event of a medical emergency, by the patient's personal physician, speaking on the phone with Dr. Itani, or by the anesthesiologist.

The late cancellation fee for these appointments will be assessed at 50% of the amount of the treatment plan estimate.

Please be aware that in medical practice emergencies and unforeseen circumstances during the course of treatment can cause unexpected delays and cause us to occasionally run behind schedule. We appreciate your understanding.

I certify that I have read, understood, and received a copy of the above Cancellation/Missed Appointment Policy. I understand my financial responsibility for dental treatment.

Patient's Name: _____ Date: _____

Patient /Guardian Signature: _____