MERIDIAN DENTAL
of Simi Valley
COSMETIC • IMPLANT • FAMILY DENTISTRY

WELCOME

Please take a moment to fill out these forms as completely as you can. If you have any questions, we are glad to help.

PRIMARY REASON FOR VISIT: _____

PATIENT INFORMATION

Name: _____ Preferred Name: _____
First Middle Last

Birth date: _____ Drivers Lic. #: _____ Social Security# : _____

Home Phone:_____ Cell Phone:_____ email: _____

Address:_____ City: _____ ZIP: _____

Employer Name:_____ Work Phone:_____ Ext: _____

Employer Address:_____ City: _____ ZIP: _____

Emergency Contact:_____ Relationship:_____ Phone:_____

FINANCIAL INFORMATION- Please provide your insurance card if available

Person Responsible for Payment: _____ Relationship:_____

Address:_____ Phone: _____
Street City Zip

INSURANCE

Are you the policy holder (Subscriber)? [ ] Yes [ ] No If No, relationship to Subscriber:_____

Insurance Name: _____ Sub. SS or Ins ID #: _____ Sub. Birthdate: _____

SECONDARY INSURANCE

Subscriber Name: _____ Relationship to subscriber: _____

Insurance Name: _____ Sub. SS or Ins ID #: _____ Sub. Birthdate: _____

MEDICAL INSURANCE -*Some dental procedures may be reimbursed by your medical insurance policy. If you provide us with your insurance card we can attempt to receive reimbursement for eligible treatment. You will receive any payments awarded for eligible treatment.

HOW DID YOU HEAR ABOUT US - PLEASE SELECT FROM THE FOLLOWING:

- ☐ Referred by Patient (please tell us who so we can thank them): _____
- ☐ Website: www.Meridandentalcenters.com
- ☐ Insurance Listing
- ☐ Advertisement (Please specify):
- ☐ Other (please describe): _____

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OFFICE & FINANCIAL POLICY

Thank you for choosing Meridian Dental. Our promise is to deliver the best and most comprehensive dental care available. The following office policies are essential for us to deliver on this promise.

Time Commitment

A scheduled appointment is a commitment of time between you and our doctor/hygienist. We reserve appointment time just for you. If you miss or cancel your appointment without at least 24-hour notice, that time is lost instead of being used by another patient. We value our patients and we do not over-schedule to respect everyone's time. In order for us to continue to provide this level of care, it is important to have adequate notice for canceled appointments.

Our office usually confirms appointments at least 48 hours in advance. Please advise the office if you need to change your appointment at that time. Our policy is to charge $100 for appointments missed or canceled without at least 24 hours prior notice. This amount will be either billed via statement or charged to your credit card.

Dental Insurance

We accept most PPO insurance plans and we can bill your dental insurance carrier (except for Denti-Cal and HMO type plans) on your behalf. The benefits that are actually paid by insurance carriers vary widely from carrier to carrier and group to group and depend primarily on the benefits negotiated and paid for by an employer, union, or other group with the insurance carrier. Very often we can provide you with an approximate estimate of your coverage prior to treatment. However, we cannot guarantee the insurance payment as estimated. Hence, any treatment rendered to you will be your financial responsibility irrespective of what your insurance pays. With your signature (below) you accept our policy and authorize Meridian Dental to 1) bill your insurance carriers on your behalf; 2) release any information regarding treatment at this office to your insurance carriers; 3) authorize payment directly to our office for any insurance benefits due to services rendered.

Payment in Full

Payment is required on the day of your appointment. If you have dental insurance, your estimated co-payment and deductible are due on that day.

Payment Options

For your convenience, we accept cash, check and all major credit cards (Visa, MasterCard, American Express and Discover). Bounced checks will be charged $35 to cover bank fees. We also offer financing programs through several finance companies to help cover the cost of your treatment. One of our programs offers a 6 month same as cash option and no penalty for early payoff. You may use our finance program for all or part of your procedure (over $1000).

How do you plan to pay for your portion of the treatment?

□ Cash □ Check □ Credit Card □ Financing program

Prepayments/Refunds

Prepayment for large treatment plans may qualify for a 5% prepayment discount. However, this discount is only valid if the entire treatment plan is completed. If less treatment is ultimately completed, the discount will be voided and the refund amount will be determined by our office to reflect the total cost of treatment provided. Additionally, all refunds for prepayment will be assessed a 6% service charge to cover expenses incurred by our office.

Photography Consent

I hereby authorize Meridian Dental to take photographs of my face, jaws, mouth, and teeth. I understand that the photographs will be used as a record of my care, and may be used for educational and promotional purposes (including but not limited to advertising, publicity, study club meetings, lectures, seminars, demonstrations, and professional publications). I further understand that images used for educational or promotional will be made in such a way that I will **not** be recognized. I do not expect compensation, financial or otherwise, for the use of these photographs. With your signature (below) you provide authorization for the use of photographs as described in this section.

Notice of Privacy Practices

Our office obeys federal and state law regarding the privacy of your health information. With you signature below you Acknowledge the Receipt of our office's Notice of Privacy Practices (you may refuse to Sign This Acknowledgment).

Dental Material Fact Sheet

The Dental Board of California has prepared a fact sheet to summarize information on the most frequently used restorative dental materials. We encourage you to discuss its content with Dr. Parvinjah. With your signature below you acknowledge receiving a copy of the Dental Material Fact Sheet.

I understand and acknowledge that I have read, understand and agree to the aforementioned policies.

Patient/Guardian Name	Signature	Date

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HEALTH HISTORY

Patient Name:_____ Date of Birth:_____

Dental History

1. What is the primary reason for your visit? Please explain:_____
2. How long since last dental visit? _____ Date of last dental x-rays (estimated): _____
3. Have you had any allergic reaction from dental treatment?_____ Explain:_____
4. Have you ever been pre-medicated for dental treatment? If YES, why? _____
5. Do you clench or grind your teeth? ____ When? _____
6. Does the amount of saliva in your mouth seem to be too little? ____
7. Does your mouth feel dry when eating a meal? ____
8. Have you experienced problems in your jaw? ____ Popping clicking Pain (circle)
9. Have you experienced any soreness or lumps in your face/mouth? ____ Where? _____
10. Does food get caught in your teeth? ____ Where? _____
11. Are you sensitive to: □ hot □ cold □ sweets □ chewing □ pressure
12. Do your gums bleed or hurt? ____ When? _____
13. Are your teeth: □ loose □ shifted □ chipped □ cracked □ discolored
14. Do you snore or have difficulty sleeping? ____ Explain: _____
15. Do you play high contact sports? ____ If yes, do you wear a mouthguard? ____
16. Are you unhappy with your past dental treatment? ____ Please explain: _____
17. Are there old fillings or dental work that you don't like? ____ Explain: _____
18. Are you interested in teeth whitening? ____
19. Are you interested in straightening your teeth with nearly invisible aligners? ____
20. Are you unhappy with the appearance of your smile? ____ Why? _____
21. What would you like to change most about the appearance of your smile (if anything) ? _____

_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physicians care now?	O Yes O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	O Yes O No	Please list any Medications & Dose:
Do you have, or have you taken, Phen-Fen or Redux?	O Yes O No	_____ _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	O Yes O No	_____ _____
Are you on a special diet?	O Yes O No	_____ _____
Do you use tobacco?	O Yes O No	_____ _____
Do you use controlled substances?	O Yes O No	_____ _____

Women are you:

Pregnant/trying to get pregnant? O Yes O No | Taking oral contraceptives? O Yes O No | Nursing? O Yes O No

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal □ Latex □ Sulfa drugs

□ Other - Please explain: _____

Do you have, or have you had any of the following?

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV positive	□	□	Cortisone Medicine	□	□	Hemophilia	□	□	Radiation Treatments	□	□
Alzheimer's Disease	□	□	Diabetes	□	□	Hepatitis A	□	□	Recent Weight Loss	□	□
Anaphylaxis	□	□	Drug Addiction	□	□	Hepatitis B or C	□	□	Renal Dialysis	□	□
Anemia	□	□	Easily Winded	□	□	Herpes	□	□	Rheumatic Fever	□	□
Angina	□	□	Emphysema	□	□	High Blood Pressure	□	□	Rheumatism	□	□
Arthritis/Gout	□	□	Epilepsy or Seizures	□	□	High Cholesterol	□	□	Scarlet Fever	□	□
Artificial Heart Valve	□	□	Excessive Bleeding	□	□	Hives or Rash	□	□	Shingles	□	□
Artificial Joint	□	□	Excessive Thirst	□	□	Hypoglycemia (diabetes)	□	□	Sickle Cell Disease	□	□
Asthma	□	□	Fainting Spells/Dizziness	□	□	Irregular Heartbeat	□	□	Sinus Trouble	□	□
Blood Disease	□	□	Frequent Cough	□	□	Kidney Problems	□	□	Spina Bifida	□	□
Blood Transfusion	□	□	Frequent Diarrhea	□	□	Leukemia	□	□	Stomach/Intestinal Disease	□	□
Breathing Problem	□	□	Frequent Headaches	□	□	Liver Disease	□	□	Stroke	□	□
Bruise Easily	□	□	Genital Herpes	□	□	Low Blood Pressure	□	□	Swelling of Limbs	□	□
Cancer	□	□	Glaucoma	□	□	Lung Disease	□	□	Thyroid Disease	□	□
Chemotherapy	□	□	Hay Fever	□	□	Mitral Valve Prolapse	□	□	Tonsillitis	□	□
Chest Pains	□	□	Heart Attack/Failure	□	□	Osteoporosis	□	□	Tuberculosis	□	□
Cold Sores/Fever Blisters	□	□	Heart Murmur	□	□	Pain in Jaw Joints	□	□	Tumor or Growths	□	□
Congenital Heart Disorder	□	□	Heart Pacemaker	□	□	Parathyroid Disease	□	□	Ulcers	□	□
Convulsions	□	□	Heart Trouble/Disease	□	□	Psychiatric Care	□	□	Venereal Disease	□	□
									Yellow Jaundice	□	□

Have you had any serious illness not listed above? O Yes O No _____

Comments: _____

_____

_____

_____

_____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-comprised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician:

_____	_____	_____	_____
Signature of Patient	Date	Physician's Name	Phone Number

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. Further, I will not hold my dentist, or any other member of his staff, responsible for any errors from omissions that I may have made in the completion of this form.

Signature of PATIENT, PARENT, or GUARDIAN _____DATE _____

FARBOD PARVINJAH, D.M.D.
2345 ERRINGER ROAD, SUITE 220
SIMI VALLEY, CA 93065
(805) 583-5589

EFFECTIVE DATE OF NOTICE: JUNE 1, 2017

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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 usually will not 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, or phone 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. Farbod Parvinjah's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____