

Patient Medical History

Circle any of the following in which you have had or have presently

- | | | |
|-----------------------------|-------------------------|---------------------|
| Headaches | Heart Murmur | Hepatitis B |
| Nausea | Mitral Valve Prolapse | Hepatitis C |
| Bleeding Problem/Hemophilia | Rheumatic Fever | AIDS/HIV |
| Anemia | Thyroid Disease | Tuberculosis |
| Circulatory Problems | Cancer or Tumor | Mononucleosis |
| High or Low Blood Pressure | Radiation Treatment | Herpes I/II |
| History of Substance Abuse | Stroke | Asthma |
| Heart Attacks | Fainting Spells | Emphysema |
| Seizures | Venereal Disease | Shortness of Breath |
| Cortisone Medication | Sickle Cell Disease | High Cholesterol |
| Kidney Disease/Transplant | Total Joint Replacement | Psychiatric: _____ |
| Diabetes | | |
| Other _____ | | |

Are you currently pregnant? Yes No

Are you allergic to or have had any reactions to the following? Please Circle the Following which

- | | | |
|---------------------------|---------------------------------------|--------------|
| Local Anesthetics | Penicillin or any other antibiotics | Sulfa Drugs |
| Barbiturates | Sedatives | Iodine |
| Aspirin | Any Metals (e.g. nickel, mercury etc) | latex rubber |
| Other (please list) _____ | | |

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No

If yes, Please Explain _____

Are you taking any medication? Yes No

If yes, what medication are you taking _____?

Patient dental History

Last dental exam and cleaning: _____

Rate your smile

0-5

Rate your Dental Health

0-5

YES NO

Have you ever had a bad experience at a dental office?

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Patient's Name _____

Date: _____

X _____
Patient's, Parent's or Legal Guardian's Signature

X _____
Dentist's Signature

Chitra Ghafari DDS PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Email: _____

Address: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Social Security Number: _____ Date of Birth: _____

Profession: _____ Employer: _____

Emergency contact name and phone number: _____

SECTION B: 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: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notices 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:
Chitra Ghafari DDS PC
Telephone: 240-631-9363

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.

SECTION B: SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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 Representatives Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

SECTION C: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____