JON SHAFQAT, D.D.S

PATIENT INFORMATION & HEALTH HISTORY

PATIENT INFORMATION

Patient's Name _____
Last First Middle

Patient's Address _____
Street City State Zip

Home Phone _____ Age _____ Occupation _____

Cell Phone _____ Date of Birth _____ Social Security # _____

Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Spouse _____ Spouse's Phone _____

Nearest Relative (Not living with you) _____ Telephone _____

Referred by _____

Patient's Dentist _____ Patient's Physician _____

My chief complaint (why you have come to an oral surgeon): _____

Pharmacy Name _____ Street _____ City _____ Ph. No _____

CREDIT INFO

Person Responsible for Account _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Social Security # _____

DENTAL INSURANCE INFO

Primary

Name of Insured: _____
Last First MI

Insured's Birth Date _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Dental Insurance Name and _____

Address _____

ID# _____ Group # _____

Secondary

Name of Insured: _____
Last First MI

Insured's Birth Date _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Dental Insurance and _____

Address _____

ID# _____ Group # _____

MEDICAL INSURACE INFO

Name of Insured: _____
Last First MI

Insured's Birth Date _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Insured's Plan Name and _____

Address: _____

ID# _____ Group # _____

PLEASE COMPLETE OTHER SIDE

		Y	N
1.	Are you being treated for any condition by a Physician? Now ☐ or in the past year ☐	☐	☐
2.	Are you taking any medicines? Now ☐ or in the past year ☐	☐	☐
	Which ones? _____		
3.	Are you taking any natural product, herbal, supplement or tea, or other natural or homeopathic remedy?	☐	☐
	If yes, are you taking any prescription or non-prescription medications for the same purpose as the herbal remedy?	☐	☐
4.	Are you allergic to any drugs, medicines or latex products?	☐	☐
	Which ones? _____		
5.	Have you ever taken any prescription drug for osteoporosis?	☐	☐
6.	Have you ever taken any prescription diet medications such as Fen/Phen?	☐	☐
7.	Do you have a pacemaker?	☐	☐
8.	Have you ever had heart trouble?	☐	☐
9.	Have you ever been told by a physician that you have a heart murmur?	☐	☐
10.	Have you ever had rheumatic fever?	☐	☐
11.	Do you have high blood pressure?	☐	☐
12.	Have you ever had chest pain?	☐	☐
13.	Do you have shortness of breath?	☐	☐
14.	Do your ankles swell?	☐	☐
15.	Do you bleed excessively when cut?	☐	☐
16.	Do you have any blood disorder such as anemia?	☐	☐
17.	Have you ever had a stroke or any seizure disorders?	☐	☐
18.	Do you have asthma or any lung disease?	☐	☐
19.	Have you ever fainted?	☐	☐
20.	Do you smoke?	☐	☐
21.	Do you now have a cold or sore throat?	☐	☐
22.	Do you have diabetes?	☐	☐
23.	Have you ever had a thyroid condition?	☐	☐
24.	Have you ever had stomach ulcers?	☐	☐
25.	Have you ever had kidney problems?	☐	☐
26.	Have you ever had hepatitis or yellow jaundice?	☐	☐
27.	Have you ever tested positive for HIV?	☐	☐
28.	Have you ever had a history or glaucoma?	☐	☐
29.	Have you ever had radiation or cobalt treatments for cancer?	☐	☐
30.	Are you or could you possibly be pregnant?	☐	☐
31.	Have you had previous surgery of any kind?	☐	☐
	Type of surgery _____		
31.	Have you ever had reactions to local anesthetic (Novocaine) or a general anesthetic? (sodium pentothal)	☐	☐
32.	Do you have a history of sleep apnea or snoring?	☐	☐
33.	Do you have a hiatal hernia or gastric reflux?	☐	☐

Date _____ Signed _____

Patient, Parent or Guardian

Patient Name: _____
Date: _____

Are You Taking, Or Have You ***Ever*** Taken Any Of These or other Bisphosphonate Medications?

Bisphosphonate Preparations Currently Available in the US

Drug	Primary Indication	Please circle	If answered yes:
Etidronate (**Didronel**)	Paget's Disease	Yes/No	For how long _____
Tiludronate (**Skelid**)	Paget's Disease	Yes/No	For how long _____
Alendronate (**Fosamax**)	Osteoporosis	Yes/No	For how long _____
Risedronate (**Actonel**)	Osteoporosis	Yes/No	For how long _____
Ibandronate (**Boniva**)	Osteoporosis	Yes/No	For how long _____
Pamidronate (**Aredia**)	Bone Metastasis	Yes/No	For how long _____
Zoledronate (**Zometa**)	Bone Metastasis	Yes/No	For how long _____
Zoledronic Acid (**Reclast**)	Osteoporosis	Yes/No	For how long _____
Denosumab (**Prolia**) (**Xgeva**)	Osteoporosis	Yes/No	For how long _____
Romosozumab **(Evenity)**	Osteoporosis	Yes/No	For how long _____

SIGNATURE _____DATE_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Jon Shafqat, D.D.S.
2023 W. Vista Way, Suite G
Vista, California 92083

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the issues and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such operations.

Patient's Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Jon Shafqat, D.D.S.
2023 W. Vista Way, Suite G
Vista, California 92083

NOTICE OF PRIVACY PRACTICES

(DENTAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") 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. This Act gives you, the patient significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", 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 only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be coordinating treatment with your general dentist.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill 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.

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.

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.

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: Office Manager

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.

Jon Shafqat, D.D.S.
2023 W. Vista Way, Suite G
Vista, California 92083

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 to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003, 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 the office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or with the Department of Health & Human Services, Office of 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.

Please contact us for more information:

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Jon Shafqat, DDS
2023 W. Vista Way, Suite G
Vista, California 92083
(760) 724-7474

FINANCIAL POLICY

Payment is expected at the time services are rendered. We accept cash, checks, American Express, Visa, Master Card, Discover and Care Credit.

If insurance will be involved during your care in our office, we will be happy to submit a claim to your insurance company as a courtesy to you. However, it is the responsibility of the patient or their guardian to know whether prior authorization is required by their insurance company prior to any office visits, surgery or hospitalization.

For insurance patients we typically will ask that a percentage of the total fee be paid at the time the services are rendered. This is only a deposit toward your total unpaid bill. After your insurance company pays, any difference remains the obligation of the patient or their guardian.

We assign all accounts over 120 days to a collection service for processing.

Should this account become past due, I agree to pay any reasonable additional fees, including any and all collection agency charges, legal fees and/or court costs, necessary to collect this account.

I agree to this financial policy, and I have read and received a copy of this document.

_____

Signature of patient or responsible party Date