HENDERSON FAMILY DENTISTRY

Dr. Mazda Berenjian, DDS

560 Dabney Drive

Henderson, NC 27536

Phone 252-438-7384

Fax 252-492-0994

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for DR. MAZDA BERENJIAN, D.D.S. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (DR. MAZDA BERENJIAN, D.D.S. Notice of Privacy provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. DR. MAZDA BERENJIAN, D.D.S.. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to DR. MAZDA BERENJIAN, D.D.S. Privacy Officer at 560 DABNEY DR., HENDERSON, NC 27536.

With this consent, DR. MAZDA BERENJIAN, D.D.S. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my dental care.

With this consent, DR. MAZDA BERENJIAN, D.D.S. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that DR. MAZDA BERENJIAN, D.D.S. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to DR. MAZDA BERENJIAN, D.D.S. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, DR. MAZDA BERENJIAN, D.D.S. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

If you are more than ten (10) minutes late for your appointment, you may be rescheduled for another day. This will be considered a broken appointment and could result in a fee. _____ Initial

All appointments scheduled at 3:00PM, must arrive on time for your appointment. We are unable to give a grace period of the last appointment of the day._____ Initial

All patients under the age of eighteen (18) are required to have a parent or legal guardian present with them at each appointment. They will not be seen or treated in the absence of a parent or legal guardian without a signed consent form. Please ask our front desk for more information or request a form. _____ Initial

I have reviewed the above statements and understood the office policies and financial policies.

_____

Signature

_____

Printed Name

_____

Date

Welcome to Henderson Family Dentistry where we love to make you smile and meet all of your dental needs. We will always do our best to give you the most up-to-date and professional care available!

Here is a list of our office policies and financial policies:

As a courtesy, Henderson Family Dentistry will file your dental claim with your insurance company. Your deductible and co-pay, or any portion not covered by your insurance company, is due at the time of service. For those patients without insurance coverage, you will be responsible for your payment in full on the day of treatment. _____Initial

As a courtesy, we will be happy to file your insurance claims as well as obtain all plan information and provisions. It is our pleasure to assist you with this; however, we encourage you to become familiar with your coverage and benefit period allowances. We strive to assist you in utilizing and maximizing your coverage and recommend that you also maintain knowledge of your benefits exhausted throughout the benefit period. Please understand that your insurance is a contract between you and your insurance company. Thus, we cannot speak on behalf of your insurance company. We cannot be responsible for settling any disputed claims or coverage.

Any estimates of charges and insurance payments are subject to modification depending on unforeseen or undiagnosable circumstances that may arise during treatment. If insurance pays less than estimated, you will be responsible for the remaining balance and will receive a statement in the mail._____Initial

If we do not receive payment from your insurance carrier within forty-five (45) days, we will notify you. The failure of your insurance carrier to reimburse our office within sixty (60) days will result in our billing you directly for the remaining balance. Please remember that you are ultimately responsible for your bill._____Initial

Broken appointments are very costly and inconvenient. If you are unable to keep your appointment, please inform us at least twenty-four (24) hours in advance. Two or more broken appointments will lead to you and your family being dismissed from our practice. An unconfirmed appointment may run the risk of being rescheduled. _____ Initial

If you have Medicaid, you must have your current Medicaid card with you. Also, if you are twenty-one (21) years of age or older you are responsible for the $4.00 co-pay. _____ Initial

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City State Zip:

Email:

Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No:

Marital Status:

Sex:

If female please answer the following:

Y N
☐ ☐ Are you taking Birth Control Pills?
☐ ☐ Are you pregnant? If Yes, # of weeks
☐ ☐ Are you nursing?

Emergency Contact: _____

Phone Number: _____

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer - Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Dialysis

Y	N	Conditions
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse

Y	N	Conditions
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Blood Thinners
☐	☐	Bone Loss Medication
☐	☐	Joint Replacement

Y	N	Conditions
☐	☐	Pain In The Jaw Joints

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Sulfur
☐	☐	Tetracycline

Other _____

Medications

Y N ☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...

Signature: _____ Date: _____