Harout Barsemian, DMD

Specialty Practice License #5283

Your answers to the following questions are for our records only and will be considered confidential information. Please fill out completely. Please print.

Patient's Name_____ Sex_____ Date of Birth ___/___/___

Address _____ Social Security # _____

City _____ State _____ Zip _____

Home Phone # _____ Business Phone # _____ Cell # _____

Email Address _____

Marital Status: _____ Employer _____

Insured's Name: _____ Insured's Employer _____

Insured's Social Security # _____ Insured's Date of Birth _____

1. Do you have (or have you had) any of the following diseases or problems?

Heart Problems	Yes___ No ___	Rheumatic Fever	Yes___ No ___
Diabetes	Yes___ No ___	Tuberculosis	Yes___ No ___
HIV	Yes___ No ___	Epilepsy	Yes___ No ___
Hepatitis or Liver Disease	Yes___ No ___	Thyroid or Goiter	Yes___ No ___
Kidney Trouble	Yes___ No ___	High Blood Pressure	Yes___ No ___

2. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes___ No___

3. Are you taking any herbal supplements or aspirin daily? Yes___No___

4. Are you taking any drugs or medicine at this time (including oral birth control medication?) Yes___No___
   If so please list_____

5. Are you allergic to or have you reacted to any medication? Yes___ No___
   If so please list_____

6. Do you have any disease, condition, or problem not listed? Yes___No___
   If so please list_____

7. Have you been treated by a physician within the last year? Yes___No___
   If so please explain_____

8. Are you pregnant? Or possibly pregnant? Yes___No___

9. Are you nursing? Yes___No___

10. Are you taking or have you taken any Biophosphonates? Fosamax, Boniva, Actonel, Zometa, Aredia, Skelid, Bonefos, Didronel. Yes___No___

All questions have been answered accurately to the best of my knowledge.

Date_____ Signature of Patient_____
(Parent or Guardian if patient is a minor)

Whom may we thank for referring you? _____

PLEASE COMPLETE AND SIGN THE OTHER SIDE

Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize **Apex Endodontics, LLC** to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or **Apex Endodontics, LLC** health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form **Apex Endodontics, LLC** may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- **Apex Endodontics, LLC** does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that **Apex Endodontics, LLC** already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature: _____ Date: _____

Dental Team: Give a copy of this signed form to the patient. Save the original in the patient's file.

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer