Pierre J. Mouradian, D.M.D. P.C., Medical Arts Bldg., Suite 801 - 1601 Walnut Street, Philadelphia, PA 19102

Registration Form including Medical and Dental History

Patient Information

Date / /

Whom may we thank for referring you?

Patient Last Name

Patient First Name | Middle Initial

Address | Apt #

City | State | Zip

Occupation: | Employer Name

E-mail:

Permission to e-mail health information to this address □ **Y** □ **N**

If Yes please initial here:

Home Phone | Work Phone | Ext

Cell Phone

Gender □ M □ F | Age | DOB / / | SSN - -

□ Single □ Minor □ Married □ Widowed □ Separated □ Divorced □ Partnered for years

Spouse's Name | DOB / / | SSN - -

Occupation | Phone Number

In case of emergency, Contact (Specify someone who does not live in your household)

Name | Relationship

Home Phone | Work | Ext | Cell

Dental Insurance Information

Who is responsible for this account ?

Relationship to patient

Name of Insurance Company

Subscriber Name | Subscriber SSN - -

Subscriber ID# | Group#

Subscriber DOB / / | Employer Name

Subscriber mailing address (if different from above)

Address

City | State | Zip

Home Phone | Work | Ext | Cell

Does patient have additional coverage? □ **Yes** □ **No** Insurance Co:

Subscriber Name | Subscriber SSN - -

Subscriber ID# | Group#

Subscriber DOB / / | Employer Name

Subscriber mailing address (if different from above)

Address

City | State | Zip

Home Phone | Work | Ext | Cell

I certify that I, and/or my dependent(s), have insurance coverage with _____ Insurance Company and assign directly to Dr. Mouradian all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that I am financially responsible for all charges whether or not insurance pays.

X

Signature of Patient, Parent, Guardian or Personal Representative

X

Please print name of Patient, Parent, Guardian or Personal Representative

Date | Relationship to Patient:

INSTRUCTIONS:

To receive treatment in this office you must answer all questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in the office. Honest answers must be given. Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided. To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Health Information" area which you are asked to sign in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT EXPRESS AND WRITTEN PERMISSION.

Medical History

Physician's Name Date of last visit: / /

Physician's Phone Number:

Do you suffer from any disability? □**Yes** □**No**

If yes please describe:

Have you ever, or do you now take illegal drugs? □**Yes** □**No**

If yes, describe and provide current status:

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

Do you have AIDS, or are you HIV-positive? □**Yes** □**No**

If yes, describe and provide current status:

Do you now have, or have you ever had venereal disease or hepatitis? □**Yes** □**No**

If yes, describe:

Have you ever had a serious injury to your head/neck or had a major operation? □**Yes** □**No**

If yes, please describe:

Have you ever had a serious illness or been hospitalized? □**Yes** □**No**

If yes, please describe:

Do you smoke? □**Yes** □**No** □ Cigarette □ Pipe □ Cigar

If yes, for how many years?

Are you taking any drugs or medications? □**Yes** □**No**

If yes, list and describe amounts and purpose:

Note: There are many drug and medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medication is essential.

Women : Are you taking birth control pills? □**Yes** □**No**

Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.

Are you pregnant? □ ***Yes*** □ ***No*** *If yes, when are you due?*

Are you nursing □ ***Yes*** □ ***No***

Have you ever had an allergic reaction to medication?				□Yes	□No
If yes, please check off box.					
□ Aspirin □ Codeine □ Latex □ Penicillin □ Sulfa □ Iodine □ Local Anesthetic					
□ Other					
Do you need to be pre-medicated prior to dental care?				□Yes	□No
Have You Ever Had Or Been Treated For:					
Anemia	□Yes	□No	Jaundice	□Yes	□No
Angina	□Yes	□No	Kidney Disease / Renal Dialysis	□Yes	□No
Arthritis, Rheumatism	□Yes	□No	Liver Disease	□Yes	□No
Artificial Heart Valves	□Yes	□No	Low Blood Pressure	□Yes	□No
Artificial joints	□Yes	□No	Mitral Valve Prolapse	□Yes	□No
Asthma	□Yes	□No	Nervous Problems	□Yes	□No
Back Problems	□Yes	□No	Pacemaker or Irregular Beats	□Yes	□No
Blood Disease	□Yes	□No	Psychiatric Care	□Yes	□No
Cancer	□Yes	□No	Radiation Treatment	□Yes	□No
Chemical Dependency	□Yes	□No	Respiratory Disease	□Yes	□No
Chemotherapy	□Yes	□No	Rheumatic Fever	□Yes	□No
Circulatory Problems	□Yes	□No	Rheumatic Heart Disease	□Yes	□No
Congenital Heart Disease	□Yes	□No	Scarlet Fever	□Yes	□No
Cortisone Treatments	□Yes	□No	Shortness of Breath	□Yes	□No
Cough, persistent to bloody	□Yes	□No	Sinus Trouble	□Yes	□No
Diabetes	□Yes	□No	Skin Rash	□Yes	□No
Emphysema	□Yes	□No	Special Diet	□Yes	□No
Epilepsy	□Yes	□No	Stomach or Intestinal Disease	□Yes	□No
Fainting or dizziness	□Yes	□No	Stroke	□Yes	□No
Glaucoma	□Yes	□No	Swollen Feet or Ankles	□Yes	□No
Hay Fever	□Yes	□No	Swollen Neck Glands	□Yes	□No
Headaches	□Yes	□No	Thyroid Problems	□Yes	□No
Heart Attack	□Yes	□No	Tonsillitis	□Yes	□No
Heart Murmur	□Yes	□No	Tuberculosis	□Yes	□No
Heart Surgery	□Yes	□No	Tumor / growth on head or neck	□Yes	□No
Herpes	□Yes	□No	Ulcer	□Yes	□No
High Blood Pressure	□Yes	□No	Weight loss unexplained	□Yes	□No
Do you have any other health issue(s) that Dr. Mouradian should be aware of?				□Yes	□No
If yes, describe:					

Dental History

Reason for today's visit □ Consultation □ Check up □ Emergency

If emergency, How long have you been feeling pain:

Former Dentist Name Phone #

Date of last dental visit? Date of last dental X-rays

How often do you brush:

How often do you floss:

How often do you use mouthwash:

Do you have bleeding gums? □**Yes** □**No**

If yes, for how long:

Place mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	□**Yes**	□**No**	Loose Teeth / Broken Fillings	□**Yes**	□**No**
Bleeding abnormally, with extractions or surgery	□**Yes**	□**No**	Mouth breathing	□**Yes**	□**No**
Blister on lips or mouth	□**Yes**	□**No**	Mouth pain	□**Yes**	□**No**
Burning sensation on tongue	□**Yes**	□**No**	Orthodontic treatment	□**Yes**	□**No**
Clicking or popping jaw	□**Yes**	□**No**	Pain around ear	□**Yes**	□**No**
Dry mouth	□**Yes**	□**No**	Periodontal / Gum treatment	□**Yes**	□**No**
Fingernail biting	□**Yes**	□**No**	Sensitive to biting / pressure	□**Yes**	□**No**
Food collection between teeth	□**Yes**	□**No**	Sensitivity to cold	□**Yes**	□**No**
Foreign objects	□**Yes**	□**No**	Sensitivity to hot	□**Yes**	□**No**
Grinding teeth	□**Yes**	□**No**	Sensitivity to sweets	□**Yes**	□**No**
Jaw pain or tiredness	□**Yes**	□**No**	Sores / Growths in your mouth	□**Yes**	□**No**
Jaw surgery	□**Yes**	□**No**	Swelling / Lumps in mouth	□**Yes**	□**No**
Lip or cheek biting	□**Yes**	□**No**	Swollen Gums	□**Yes**	□**No**

NOTE: A change in your health status should be reported to the office at the earliest possible time.

Permission To Release Health Information

I grant the right to Dr. Mouradian to release health information obtained from me, and information about my dental treatment to third party payors, and / or health practitioners.

Person completing the form: Signature:**X**_____

Witness:_____ Print Name:_____

If other than patient, indicate relationship:_____ Date____/____/____

I have read all the information on this registration form and have completed all of the above answers. I certify that the forgoing questions have been accurately answered to the best of my knowledge. I will notify you of any changes in my health status or any of the above information.

Signature:**X**_____ Date____/____/___

Relationship to Patient:_____

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Dr. Mouradian's Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

Patient Name:_____ Date___/___/____

Signature:**X**

HIPAA Notice of Privacy Practices

Pierre J. Mouradian, D.M.D. P.C. & Kim Tran, D.M.D.
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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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of you health care with a third party. For example, we would disclose your protected health information, as necessary, to home health agency that provides care for you. For example, your protected health information may be provide to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign in your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Security of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician release your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Your have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.