Oren Rahmanan, DDS
One Rockefeller Plaza
New York, NY 10020
212-581-6736

Dear Patient:

Welcome to our practice. Thank you for entrusting us to provide your dental care.

We will file your insurance claim electronically and accept assignment of benefits. You will be responsible for your deductible, co-payment and/or your co-insurance. A copy of your dental insurance card will be required to provide these services for you.

A credit card will be kept on file for payment on any charges not covered by the insurance carrier. These charges will automatically be billed to the credit card.

Please let us know if you have any questions regarding our financial policies.

Sincerely,
Oren Rahmanan, DDS

I, _____ hereby authorize Oren Rahmanan, DDS to submit an insurance claim on my behalf, accept assignment of benefits and charge the balance of my dental fees not covered by my dental insurance.

Signature: _____

Credit Card #:_____

Exp. Date: _____ Security Code: _____

Health History Form

Name_____ Spouse_____

Social Security #_____ Date of Birth_____

Address_____

Home Phone _____Business Phone _____Cell Phone_____

E-Mail Address_____ Do you have dental insurance? _____

Employer_____ Occupation_____

Will someone other than you be responsible for this account? Who? _____

Who may we thank for referring you? _____

Medical History

Name & address of physician _____

In case of emergency, contact _____ phone _____relationship_____

The following conditions require antibiotic prophylaxis, as recommended by the American Heart Association. Please circle if you have been diagnosed with:

Artificial (prosthetic) Heart Valve(s)
Previous Infective Endocarditis
Damaged Valves in Transplanted Heart
Congential Heart Disease (CHD)
Unrepaired, cyanotic CHD
Repaired (completed) in last 6 months
Repaired CHD with residual defects

Do you wear contact lenses? Y or N

Have you had an orthopedic joint replacement? Y or N

Do you take oral bisphosphonates (Actonel, Boniva, Fosamax)? Y or N
If yes, how long have you been taking this? _____

Have you been treated with IV bisphosphonates (Aredia or Zometa) Y or N
If yes, how long have you been taking this? _____

Have you ever taken fen-phen (fenfluramine/phentermine)? Y or N
If yes, have you had a cardiac exam by your physician?

Women Only:
Are you pregnant? Y or N
Nursing? Y or N
Taking birth control pills? Y or N
Hormone replacement therapy? Y or N

Men Only:
Are you taking meds for ED? Y or N

PLEASE CIRCLE to indicate if you have or had any of the following diseases or problems:

Angina
Arteriosclerosis
Artificial Heart Valves
Congenital heart defects
Congestive heart failure
Coronary artery disease
Damaged heart valves
Repaired heart valves
Heart attack
Heart murmur
High blood pressure
Low blood pressure
Mitral valve prolapse
Pacemaker
Rheumatic Heart Disease
Rheumatic Fever
Chest pain upon exertion
Abnormal bleeding

AIDS or HIV infection
Anemia
Arthritis
Rheumatoid Arthritis
Asthma
Bronchitis
Cancer
Chemotherapy
Radiation Treatment
Crohn's Disease
Diabetes
Drug dependency
Dry mouth
Eating disorders
Emphysema
Epilepsy
Fainting/Seizures
Gastrointestinal disease

G.E. Reflux/heartburn
Glaucoma
Headaches/migraines
Hemophilia
Hepatitis
Herpes
Jaundice
Liver disease
Kidney problems
Mental health disorders
Malnutrition
Night sweats
Neurological disorders
Organ transplant
Osteoporosis
Persistent swollen glands
Paget's Disease
Polio

Prolonged Cough
Psychiatric treatment
Recurrent infections
Sickle Cell Anemia
Sjogrens Disease
Sudden weight change
Sexually trans. disease
Shortness of breath
Sinus trouble
Sleep disorder
Sores/ulcers in mouth
Stroke
Lupus
Tuberculosis
Thyroid problems
Ulcers
Excessive urination
Other_____

Medical History (continued)

Are you now under the care of a physician? _____

Are you in good health?_____ Date of last physical exam? _____

Have you had a serious illness or operation within the last 5 years? _____ Please explain_____

_____

Are you allergic to? Circle your response

Local anesthetics
Aspirin
Penicillin or other antibiotics
Barbiturates, sedatives or sleeping pills
Sulfa drugs
Codeine or other narcotics
Latex
Iodine
Hay fever/seasonal
Other (please specify)

Are you taking any of the following medications?

Analgesics	Antibiotics	Anticoagulants
Antidepressants	Antihistamines	AID/HIV Meds
Birth Control Pills	Hormone Replacements	Chemotherapy
Steroids	Bisphosphonates	Digitalis
Heart Medication	Diabetes Medication	Nitroglycerin
Sedatives	Thyroid Medication	Tranquilizers
Aspirin ___mg	ED Medication	Hypertension Meds
Herbal Supplements		Anticholesterol Meds

List medications:_____
_____
_____

Dental History

How do you feel about the appearance of your smile? _____

If you could change anything about your teeth, what would it be? _____

Do your gums bleed when you brush or floss? _____

Are your teeth sensitive to hot, cold, sweets or pressure? _____

Is your mouth dry? _____

Have you had periodontal treatment? _____ Have you had orthodontic treatment? _____

Are you currently experiencing any discomfort or pain? _____

Do you have headaches, earaches or neck pain? _____

Do you have any clicking, popping or discomfort in the jaw? _____

Do you grind your teeth? _____ Do you wear a nightguard? _____

Do you suffer from sores or ulcers in your mouth? _____

Do you participate in active recreational activities? _____

Have you ever had a serious injury to your head or mouth? _____

How long has it been since your last dental exam? _____Last x-rays? _____

Please add anything you feel is important: _____
_____
_____

DATE _____ Signature_____ Drs. Initials _____
DATE _____ Signature_____ Drs. Initials _____
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DATE _____ Signature_____ Drs. Initials _____
DATE _____ Signature_____ Drs. Initials _____

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 212-581-6736.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

OREN RAHMANAN, DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).