Mak Dental
"A smile from the heart"

• MOUNIR GUIRGUIS DDS •
• A SMILE FROM THE HEART •

Tel: 707-554-2600
480 REDWOOD ST SUITE 13
VALLEJO, CA 94590

PATIENT INFORMATION

Date: ☐ NEW PATIENT ☐ UPDATE

Patient:
LAST FIRST MI PREFERRED TITLE

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

☐ MALE
☐ FEMALE

Patient Date of Birth: Patient SSN:

Address:
ADDRESS LINE 1
ADDRESS LINE 2
CITY ST ZIP CODE

HOME:
CELL:
OTHER:
PAGER:
FAX:

E-Mail:

Referral? ☐ Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

INSURANCE INFORMATION

Subscriber:
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PREVIOUS DENTIST INFORMATION

Dentist: Telephone:

Clinic/Facility:

Address:

CITY ST ZIP CODE

Reason for changing:

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DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: ..... Treatment Type: .....

☐Y☐N Are you currently having dental discomfort? If yes, explain: .....
☐Y☐N Do you care about tooth whitening?
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: .....
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you want to become a regular continuing care patient in our practice?

The most important concerns regarding my dental treatment are:

.....

What factors are most important for your satisfaction with our office?

.....

Are you interested in having more information about implants? ☐Y☐N

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (Thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

.....

☐Y☐N Any unusual speech habits? If yes, explain: .....
☐Y☐N Any lost teeth? If yes, list: .....
☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

.....

PRIMARY PHYSICIAN INFORMATION

Physician: ..... Telephone: .....

Clinic/Facility: .....

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? .....
☐Y☐N Any serious illnesses/surgeries? .....
☐Y☐N Use tobacco in any form? If Yes, Type: .....
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: .....

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

HEALTH HISTORY

• MOUNIR GUIRGUIS DDS •

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480 REDWOOD ST SUITE 13
VALLEJO, CA 94590

Patient First Name | MI | Last Name | Birthdate | Sex ☐ Male ☐ Female

GENERAL HEALTH QUESTIONS

1. Have you had any serious illness, operations or hospitalizations? ☐ Yes ☐ No

2. Are you under a physician's care at this time? ☐ Yes ☐ No
   Name, address and phone # of physician:

Do you have or did you ever have any of the following?

Cardiovascular Health

3. High blood pressure ☐ Yes ☐ No
4. Angina or heart attack ☐ Yes ☐ No
5. Chest pain on physical exertion ☐ Yes ☐ No
6. Coronary artery blockage or treatment (bypass, stent, etc.) ☐ Yes ☐ No
7. Heart valve problem or replacement ☐ Yes ☐ No
8. Heart murmur ☐ Yes ☐ No
9. Heart disease, problem or treatment ☐ Yes ☐ No
10. Rheumatic fever ☐ Yes ☐ No
11. Past use of Fen-Phen ☐ Yes ☐ No
12. Irregular heart beat or pacemaker ☐ Yes ☐ No
13. Difficulty breathing when lying down ☐ Yes ☐ No
14. Stroke ☐ Yes ☐ No
15. Low blood pressure ☐ Yes ☐ No

Respiratory Health

16. Asthma ☐ Yes ☐ No
17. Emphysema or respiratory problems ☐ Yes ☐ No
18. Chronic sinus problems ☐ Yes ☐ No
19. Tuberculosis or persistent cough ☐ Yes ☐ No

Endocrine/Blood/Immune Health

20. Diabetes ☐ Yes ☐ No
21. Frequent thirst or frequent urination ☐ Yes ☐ No
22. Thyroid problems ☐ Yes ☐ No
23. Abnormal bleeding, bruise easily ☐ Yes ☐ No
24. Hemophilia ☐ Yes ☐ No
25. Anemia/blood disease ☐ Yes ☐ No
26. Cancer ☐ Yes ☐ No
27. Radiation therapy/chemotherapy ☐ Yes ☐ No
28. HIV infection/AIDS ☐ Yes ☐ No
29. Cold sores/canker sores ☐ Yes ☐ No
30. Organ transplant ☐ Yes ☐ No
31. Blood transfusion ☐ Yes ☐ No

Muscular-Skeletal/CNS/Mental Health

32. Joint replacement ☐ Yes ☐ No
33. Arthtritis ☐ Yes ☐ No
34. Osteoporosis ☐ Yes ☐ No
35. Fainting spells or dizziness ☐ Yes ☐ No
36. Seizures ☐ Yes ☐ No
37. Numbness or muscle weakness ☐ Yes ☐ No
38. Multiple sclerosis ☐ Yes ☐ No
39. Mental retardation ☐ Yes ☐ No
40. Dementia/Alzheimer's disease ☐ Yes ☐ No
41. Anxiety/Nervousness ☐ Yes ☐ No
42. Mental health treatment ☐ Yes ☐ No

Gastro-Intestinal/Genito-Urinary Health

43. Hepatitis (A, B, C or other) ☐ Yes ☐ No
44. Liver disease ☐ Yes ☐ No
45. Kidney disease/dialysis ☐ Yes ☐ No
46. Stomach trouble/ulcers ☐ Yes ☐ No
47. Sexually transmitted disease ☐ Yes ☐ No

Medication Allergies and Other Allergies

48. Penicillin or other antibiotics ☐ Yes ☐ No
49. Sulfa drugs ☐ Yes ☐ No
50. Dental antesthetic ☐ Yes ☐ No
51. Aspirin ☐ Yes ☐ No
52. Codeine/narcotics ☐ Yes ☐ No
53. Iodine ☐ Yes ☐ No
54. Latex products ☐ Yes ☐ No
55. Metals/nickels/jewelry ☐ Yes ☐ No
56. Other: ☐ Yes ☐ No

Females Only

57. Are you pregnant? ☐ Yes ☐ No
58. Are you nursing now? ☐ Yes ☐ No
59. Do you take birth control pills? ☐ Yes ☐ No

Medications

60. Are you taking any prescription medications, over the counter medications or herbal medicines? ☐ Yes ☐ No
    If so, please list them and the dose taken:

61. Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? ☐ Yes ☐ No

Social

62. Do you use tobacco? ☐ Yes ☐ No Quantity _____ Per Day
63. Do you use alcohol? ☐ Yes ☐ No Quantity _____ ☐ Per Day ☐ Per Week
64. Do you use recreational drugs? ☐ Yes ☐ No Quantity _____ Per Day
65. Do you have any other medical conditions not already listed above? ☐ Yes ☐ No
    Please list:

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the unsigned, consent to the performing of x-rays and examination.

Signature of PATIENT or GUARDIAN _____ Date _____

Signature of DENTIST _____ ID# _____ Date _____

UPDATE Have there been any changes in your medical history, including any medications that you take, since you last completed this form? ☐ Yes ☐ No

Signature of PATIENT or GUARDIAN _____ Date _____

Signature of DENTIST _____ Date _____

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Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

Minors must be accompanied by a parent or legal guardian. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover)
  - Various financing options with CareCredit® and Icare®

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
- **Short canceled or missed appointments** may be charged up to twenty dollars.

By signing below I acknowledge I have read and understand the guidelines above.

Signature: Date:

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: **Date:**

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

☐ I give permission for the following communications to be used by Dr. Mounir Guirguis **(please check all that apply)** :

☐ Cell phone: ☐Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

☐ I am granting permission for Dr. Mounir Guirguis DDS to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for Dr. Mounir Guirguis DDS to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back
☐ Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other – please list:

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PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Mak Dental of the dental benefits otherwise payable to me.

I hereby authorize Dr. Guirguis to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature: Date:

Mak Dental
480 Redwood St
Suite 13
Vallejo
California, 94590

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

OUR RESPONSIBILITIES

We at Mak Dental understand that medical information about you and your health is personal. Applicable federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect This Notice takes effect 02/26/2018, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

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

To Treat You: We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Billing and Payment For Services: We can use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We can use and disclose your health information in connection with our healthcare operations which 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 another 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 purposes without your written permission.

Required by Law: We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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 authorized 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.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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

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, mailing, 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 at 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Patricia Banda
Telephone: 7075542600
E-mail: frontoffice@makdental.net
Address: 480 Redwood St
Suite 13
Zip Code: 94590
State: California
City: Vallejo