B. David Zinati, D.D.S. Orthodontics
for Children & Adults
www.zinati.com

WELCOME TO OUR OFFICE

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION IS STRICTLY CONFIDENTIAL.

(PLEASE FILL OUT ALL 5 PAGES & PRINT CLEARLY)

Patient Information

DATE ____________________ SEX ________ CELL PHONE NO (   ) ____________________

PATIENT'S NAME ______________________________ AGE ______ BIRTHDATE ____________
LAST FIRST M.

ADDRESS ____
city state zip

DENTIST'S NAME ______________________________ TELEPHONE (   ) ____________

PHYSICIAN'S NAME ______________________________ TELEPHONE (   ) ____________

REFERRED BY ____

SCHOOL ______________________________________ GRADE ____________

HOBBIES ____________________ SPORTS ________________ INTERESTS ________________

BROTHER'S AGES ________________________ SISTER'S AGES ________________________

Responsible Party Information

NAME ____
LAST FIRST MIDDLE

ADDRESS ____
city state zip

HOME PHONE (   ) ____________ WORK PHONE (   ) ____________ CELL PHONE (   ) ____________

EMAIL ______________________ BIRTHDATE ____________________

RELATIONSHIP TO PATIENT ____________________ SOCIAL SECURITY NO. ____________________

EMPLOYER ______________________________ OCCUPATION ______________________________

SPOUSE'S NAME ______________________________ WORK PHONE (   ) ____________

NAME OF RELATIVE OR FRIEND TO BE CONTACTED IN CASE OF EMERGENCY (Not in Immediate Household):

NAME ____________________ RELATION ____________________ PHONE (   ) ____________

ADDRESS ____

Insurance Information

IS PATIENT COVERED BY INSURANCE PLAN COVERING ORTHODONTIC TREATMENT? ☐ YES ☐ NO

NAME OF INSURED ______________________ RELATIONSHIP TO PATIENT ______________________

BIRTHDATE ______________________ SOCIAL SECURITY NO. ______________________

WORK PHONE (   ) ______________ extension ________ DATE EMPLOYED ______________________

NAME OF THE EMPLOYER ______________________

ADDRESS OF THE EMPLOYER ______________________
city sate zip

INSURANCE COMPANY ______________________ MEMBER ID ______________________

UNION OR LOCAL NO. ______________________ GROUP NO ______________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO

IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURED ______________________ RELATIONSHIP TO PATIENT ______________________

BIRTHDATE ______________________ SOCIAL SECURITY NO. ______________________

WORK PHONE (   ) ______________ extension ________ DATE EMPLOYED ______________________

NAME OF THE EMPLOYER ______________________

ADDRESS OF THE EMPLOYER ______________________
city sate zip

INSURANCE COMPANY ______________________ GROUP NO. ______________________

UNION OR LOCAL NO. ______________________

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

SIGNATURE (PARENT'S SIGNATURE IF MINOR): ______________________ DATE: ______________

UPDATES (DATE AND INITIAL) ______________________ ______________________

Signature on File

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. ZINATI. DR. ZINATI IS AUTHORIZED TO RELEASE ANY INFORMATIONTO INSURANCE COMPANY(S), CLAIM ADMINISTRATOR(S) AND CONSULTING HEALTH CARE PROFESSIONALS.

SIGNATURE (INSURED PERSON): ______________________ DATE: ______________

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

☐yes ☐no ☐dk/u Does patient follow directions well?
☐yes ☐no ☐dk/u Does patient brush his/her teeth conscientiously?
☐yes ☐no ☐dk/u Does patient have learning disabilities or need extra help with instructions?
☐yes ☐no ☐dk/u Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, has the patient had:

☐yes ☐no ☐dk/u Birth defects or hereditary problems?
☐yes ☐no ☐dk/u Bone fractures, any major accidents?
☐yes ☐no ☐dk/u Rheumatoid or arthritic conditions?
☐yes ☐no ☐dk/u Endocrine or thyroid problems?
☐yes ☐no ☐dk/u Kidney problems?
☐yes ☐no ☐dk/u Diabetes?
☐yes ☐no ☐dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐yes ☐no ☐dk/u Stomach ulcer or hyperacidity?
☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis or pneumonia?
☐yes ☐no ☐dk/u Problems of the immune system?
☐yes ☐no ☐dk/u AIDS or HIV positive?
☐yes ☐no ☐dk/u Hepatitis, jaundice or liver problem?
☐yes ☐no ☐dk/u Fainting spells, seizures, epilepsy or neurological problem?
☐yes ☐no ☐dk/u Mental health disturbance or behavioral problem?
☐yes ☐no ☐dk/u Vision, hearing, tasting or speech difficulties?
☐yes ☐no ☐dk/u Loss of weight recently, poor appetite?
☐yes ☐no ☐dk/u History of eating disorder (anorexia, bulimia)?
☐yes ☐no ☐dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐yes ☐no ☐dk/u High or low blood pressure?
☐yes ☐no ☐dk/ u Tires easily?
☐yes ☐no ☐dk/u Chest pain, shortness of breath or swelling ankles?
☐yes ☐no ☐dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐yes ☐no ☐dk/u Skin disorder?
☐yes ☐no ☐dk/u Does the patient eat a well-balanced diet?
☐yes ☐no ☐dk/u Frequent headaches, colds or sore throats?
☐yes ☐no ☐dk/u Eye, ear, nose or throat condition?
☐yes ☐no ☐dk/u Hayfever, asthma, sinus trouble or hives?
☐yes ☐no ☐dk/u Tonsil or adenoid problems?

Allergies or reactions to any of the following:

☐yes ☐no ☐dk/u Local anesthetics (Novocaine or Lidocaine)
☐yes ☐no ☐dk/u Aspirin
☐yes ☐no ☐dk/u Ibuprofen (Motrin, Advil)
☐yes ☐no ☐dk/u Penicillin or other antibiotics
☐yes ☐no ☐dk/u Sulfa drugs
☐yes ☐no ☐dk/u Codeine or other narcotics
☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)
☐yes ☐no ☐dk/u Latex (gloves, balloons)
☐yes ☐no ☐dk/u Vinyl
☐yes ☐no ☐dk/u Acrylic
☐yes ☐no ☐dk/u Animals
☐yes no dk/u Foods (specify) ______________________________
☐yes ☐no ☐dk/u Other substances (specify) __________________________
☐yes ☐no ☐dk/u Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

Medication __________________ For ____________________
Medication __________________ For ____________________
Medication __________________ For ____________________

☐yes ☐no ☐dk/u Does the patient currently have or ever had a substance abuse problem?
☐yes ☐no ☐dk/u Does the patient chew or smoke tobacco?
☐yes ☐no ☐ dk/u Operations? Describe: ___________________________
☐yes ☐no ☐dk/u Hospitalized? For:______________________________
☐yes ☐no ☐dk/u Other physical problems or symptoms?
Describe: ______________________________________
☐yes ☐no ☐dk/ u Being treated by another health care professional?
For:____
Date of most recent physical exam? _________________

Are there any other medical conditions that we should be aware of?

____

GIRLS / WOMEN ONLY

☐yes ☐no ☐dk/u Has the patient started her monthly periods? If so, approximately when? ________________________
☐yes ☐no ☐dk/u Is the patient pregnant?
☐yes ☐no ☐dk/u Are you anticipating becoming pregnant?

Boys: Voice change at what age? ___________________________

Father's height: ___________ Mother's Height: ___________

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

Bleeding disorders, Diabetes, Arthritis, Metabolic disturbance, Severe allergies, Unusual dental problems, Jaw size imbalance, Any other family medical conditions that we should know about?

____

____

DENTAL HISTORY

Now or in the past, has the patient had:

☐yes ☐no ☐dk/u Started teething very early or late?
☐yes ☐no ☐dk/u Primary (baby) teeth removed that were not loose?
☐yes ☐no ☐dk/u Permanent or "extra" (supernumerary) teeth removed?
☐yes ☐no ☐dk/u Supernumerary (extra) or congenitally missing teeth?
☐yes ☐no ☐dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
☐yes ☐no ☐dk/u Teeth sensitive to hot or cold; teeth throb or ache?
☐yes ☐no ☐dk/u Jaw fractures, cysts or mouth infections?
☐yes ☐no ☐dk/u "Dead teeth" or root canals treated?
☐yes ☐no ☐dk/u Bleeding gums, bad taste or mouth odor?
☐yes ☐no ☐dk/u Periodontal "gum problems"?
☐yes ☐no ☐dk/u Food impaction between teeth?
☐yes ☐no ☐dk/u Thumb, finger, or sucking habit? Until what age _____?
☐yes ☐no ☐dk/u Abnormal swallowing habit (tongue thrusting)?
☐yes ☐no ☐dk/u History of speech problems?
☐yes ☐no ☐dk/u Mouth breathing habit, snoring or difficulty in breathing?
☐yes ☐no ☐dk/u Tooth grinding, jaw clenching clicking or locking?
☐yes ☐no ☐dk/ u Any pain in jaw or ringing in the ears?
☐yes ☐no ☐dk/u Any pain or soreness in the muscles of the face or around the ears?

☐yes ☐no ☐dk/u Difficulty encountered in chewing or jaw opening?
☐yes ☐no ☐dk/u Aware of loose, broken or missing restorations (fillings)?
☐yes ☐no ☐dk/u Any teeth irritating cheek, lip, tongue or palate?
☐yes ☐no ☐dk/u Concerned about spaced, crooked or protruding teeth?

Aware or concerned about under or over developed jaws?

____

"Gum Boils", frequent canker sores or cold sores? ________________

☐yes ☐no ☐dk/u Taking any forms of fluoride?
☐yes ☐no ☐dk/u Any relative with similar tooth or jaw relationships?
☐yes ☐no ☐dk/u Had periodontal (gum) treatment?
☐yes ☐no ☐dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?
☐yes ☐no ☐dk/u Any serious trouble associated with any previous dental treatment?
☐yes ☐no ☐dk/u Ever had a prior orthodontic examination or treatment?
☐yes ☐no ☐dk/u Been under another dentist's care?
Specialist ______________________________
Other ________________________________

How often does your child brush? _____ Floss? _____

What is your primary concern? Why are you here? ____

____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

I also hereby authorize Dr. Zinati's office or the lab to take any X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by said doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all recommended forms of treatment mutually agreed upon by the doctor and myself. I consent to the use of the appropriate medications, anesthetics, and therapy that may be indicated in connection with the above-named patient. I understand that there may be certain risk when using anesthetic agents. Furthermore, I authorize and consent that the Doctor choose and employ such assistance as deemed fit to provide the recommended treatment.

Signed: ____ Date Signed: ________________
(Patient or Parent)

Signed: ____ Date Signed: ________________
(Dental Staff Member)

Patient's Name: ____________________ Date: ________________

Esthetic Questionnaire

1. Do you like the overall appearance of your teeth & smile? ________________ ☐ YES ☐ NO
   if NO, please describe. ________________

2. Do you consider your teeth to be in good alignment (straight)? ________________ ☐ YES ☐ NO
   if NO, please describe. ________________

3. Do you like the way your upper and lower teeth come together? ________________ ☐ YES ☐ NO
   if NO, please describe. ________________

4. Do you consider your teeth unattractive? ________________ ☐ YES ☐ NO

☐ protruding ☐ overlapping /crowding ☐ artificial looking ☐ yellowish

☐ retruding ☐ hidden ☐ stained ☐ gummy smile

☐ spacing ☐ chipped ☐ excessively worn

5. Do you consider your existing fillings or dental work unattractive? ________________ ☐ YES ☐ NO
   if YES, please describe. ________________

6. Do you like the shape of your teeth? ________________ ☐ YES ☐ NO
   if NO, please describe. ________________

7. Do you consider your gums unattractive? ________________ ☐ YES ☐ NO

☐ swollen ☐ bleed easily ☐ show too much gum, smiling

☐ red ☐ receded ☐ show not enough gum, smiling

8. Is there anything about your face that you don't like? ________________ ☐ YES ☐ NO

☐ nose ________________ ☐ lips ________________

☐ chin ________________ ☐ profile ________________

Please Tell us your concern (why are you here?) and what do you want specifically to achieve with orthodontic treatment?

____

____

____

Notice of Privacy Practices

Dr. B. David Zinati, DDS
Orthodontics for Children and Adults

By reading & signing this form, it is understood that ENGLISH is the language that I understand and use to communicate; otherwise I will have it translated for me by a third party before I sign.

Name: ______________________

Date: _______________

Initials: ________

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Notice of Privacy Practices

This Notice describes how your health information 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.

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect ____August 1, 2013_______, and will remain in effect until we replace it.

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 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. For more information about our privacy practices or additional copies of this Notice, please contact us (contact information below).

Uses and Disclosures of Health Information

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

For example:

Treatment:
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment:
We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations:
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, 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 is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email:
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership:
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

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

Public Health:
We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative, we believe is responsible for the abuse or harm.

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 official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders:
We may contact you to provide you with appointment reminders or information about treatment alternatives, account balance, or other health-related benefits and services that may be of interest to you., via voicemail, email, SMS (text messages to your cell phone), postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

Disclosure Accounting:
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

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 of how payments will be handled under the alternative means or location you request.

Breach Notification:
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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.

Questions and Complaints:
If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Dr. Zinati

Telephone: 310-652-2010 or Fax: 310-424-7136

E-mail: zinatiorthodontics@gmail.com

Address: 8500 Wilshire Blvd. #818. Beverly Hills, CA 90211

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I,______________________________, have received a copy of the Dr. Zinati's Notice of

Privacy Practices.

____ [Please Print Name]

____ [Signature]

____ [Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: ____

Relationship to Patient ____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)