Patient Information **Date:_____**

Patient Name: _____Date of Birth:_____Age:

Male____Fem____Parent name if patient is a minor:_____

Marital Status:____Social Security#:_____TDL:_____

Home Address:_____Home Phone:_____

Cell Phone:_____E-mail:_____

City:_____State:_____Zip:_____

Employed By (if student name of school/college)_____

Work Address:_____Work Phone:_____
City:_____State:_____Zip:_____

Whom may we thank for referring you?_____

Responsible Party or Guarantor of Insurance

Name of person responsible for this account:_____
Relationship to Patient:_____
Is this person a patient in our office?_____
Address_____Home Phone_____

Driver's License#_____Date of Birth_____
S.S#_____Employer_____
Work Phone_____Ext_____

Patient Medical History Date:_____

Physician_____Phone:_____Date of last exam_____

1) Are you under medical treatment now? Y N
2) Have you ever been hospitalized for a surgical operation or serious illness? Y N
3) List any medications you are taking including over-the-counter drugs:_____
_____
_____
4) Do you smoke, use chewing tobacco or snuff? Y N
5) Do you use alcohol, cocaine or other drugs? Y N
6) Are you ALLERGIC to any medications? Y N

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7) Are you having any pain or discomfort today? Y N
The reason for your visit?_____
8) Do you feel especially nervous about your dental visit? Y N
9) Women: Are you pregnant? Y N
Do you take oral contraceptives? Y N
10) Circle any of the conditions that apply to you now or in the past:

Heart murmur	TMJ/Joint Pain	Heart Surgery
Heart Pace Maker	Heart failure	Congenital Heart Defect
Kidney Disease	Artificial Heart Valve	Thyroid Disease
Venereal Disease	Liver Disease	Tuberculosis
Nervousness	Drug Addiction	Asthma
Ulcers	Cold Sores	Arthritis
Diabetes	Stroke	Angina
Glaucoma	AIDS	Blood Transfusion
Cortisone Medicine	HIV infection	Sickle Cell Anemia
Rheumatic Fever	Radiation Therapy	Chemotherapy
Psychiatric Treatment	Cancer	High Blood Pressure
Artificial Joint (knee, hip, elbow.)		Epilepsy or Seizures

To the best of my knowledge, all of the preceding answers are true and correct. If ever I have changes in my health or if my medicines change, I will inform the doctor at the next appointment without fail.

SignatureX_____

Dr. Signature:_____ Date:_____

Leila Ann Suki, D.D.S.

In an effort to keep our focus on patient care and in order to keep staff expenses within reason, we will bill your credit card on file for balances remaining after insurance payments are received. You will be sent a receipt for your records in a timely manner.

Please provide your credit card number on the line below:

Signature authorizing credit card billing of any balances on my account:

Expiration date:----------

Today's date:----------

Balance in full is expected at time of service if you are unable to provide a credit card number.

Office Policy

1) **The patient is responsible for co-payments and any balances remaining after dental insurance payments to our office. In the event that insurance does not reimburse our office within 60 days, the patient will be responsible for the balance.**

Please understand that dental coverage is based on an agreement between your employer and the insurance carrier, mostly arrived at for the purpose of profit to the insurance company!
It is important for you to know that, when we give you estimates, we try our best to arrive at an accurate figure.
It is as a courtesy that we file your insurance for you, so please be advised that there will certainly be a discrepancy between our quotes and actual insurance payments.

2) **There is a 45$ charge for broken appointments without a 24 hour notice. We try our best to stay on schedule because we respect your time and effort to be here. We hope that you feel the same about our time.**

3) **Last but not least, we want you to know that we are a family here and urge you to communicate any concerns, whether they are about aspects pertaining to dental treatment, financial concerns or other matters of importance to you.**

Finally Welcome Aboard!!

I ---------- understand that there is a charge for cancellation without 24-hour notice and that I am responsible for balances remaining after insurance payments to this office.
Signature of responsible party_____
Date_____

Leila Ann Suki, D.D.S
2424 W. Holcombe Blvd. #202
Houston, Texas 77030

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

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 the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

(This Form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision.)

Leila A. Suki, DDS 2424 W. Holcombe Blvd. #202 Houston, TX 77030

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law 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 immediately, 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 the changes in our privacy practices and 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 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 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 or disclose your health information to obtain payment for services we provide for you.

Healthcare Options: 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 yo 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 health care 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 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders(such as voicemail messages, postcards, 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 and staff time. You may also request access by sending us a letter to the address at the end of this Notice. You will be charged for postage if you request copies of your health information mailed to you. 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 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 one 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 website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPALINTS

If you want more information about our privacy practices or have questions or comments, pleas 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 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 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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We have the right to 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.

Contact Officer: Dr. Leila Ann Suki
Telephone: 713-664-1004 Fax: 713-664-4032
E-mail: smilesbysuki@yahoo.com
Address: 2424 West Holcombe Blvd. Suite 202 Houston, Texas 77030