St. Louis Office
777 S. New Ballas Rd, #116E
St. Louis, MO 63141
PHONE: 314-4BRACES
FAX: 314-997-7554
E-MAIL: info@smilesaintlouis.com

Lake Saint Louis Office
104 Brevco Plaza
Lake Saint Louis, MO 63367
PHONE: 636-561-4615
FAX: 636-561-9001

Springfield Office
1320 East Kingsley, #B
Springfield, MO 65804
PHONE: 417-881-7490
FAX: 417-881-3993
E-MAIL: farhadmoshiri springfield@yahoo.com

Patient Information

Name ____
LAST FIRST MIDDLE

Email (Home) ______________________ (Work) ______________________

Home Address ____
STREET CITY/STATE ZIP

Home Phone __________ Birthdate __________ Age ____ Social Security No. __________

School/Employer ______________________ Hobbies/Interest ______________________

If patient is a minor, give parent or guardian's name ______________________

Names and ages of other children in your family ______________________

Whom may we thank for referring you to our office? ______________________

Family Dentist ______________________ Date of Last Visit: ______________________

Primary Care Physician ______________________ Date of Last Visit: ______________________

Responsible Party Information

Name ____ S M D W
LAST FIRST MIDDLE Marital Status

Email (Home) ______________________ (Work) ______________________

Home Address ____
STREET CITY/STATE ZIP

How long at this address? _____ Home Ph __________ Work Ph __________ Cell Ph __________

Previous Address (if less than 3 years) ______________________

Social Security No. __________ Birthdate __________ Relationship to Patient __________

Other Responsible Party - Emergency Contact

Name ______________________ Relationship to Patient ______________________

Email ______________________ Phone ______________________

Employer ______________________ No. Years Employed ________ Birthdate __________

INSURANCE INFORMATION

Primary Dental Insurance Information

(this portion must be filled out completely)

Subscriber's Name ____________________________ Subscriber's SSN No. or Alt. ID ________________________________

Subscriber's Address______________________________________ City________________ State____________ Zip _________

Email (Home) ____Subscriber's Birthdate ______________________________

Insurance Company ________________________________ Group No. __________________ Local No. ___________________

Insurance Co. Address ____ Phone _____________________________________

Secondary Dental Insurance Information

Subscriber's Name ____________________________ Subscriber's SSN No. or Alt. ID ________________________________

Subscriber's Address______________________________________ City________________ State____________ Zip _________

Email (Home) ____ Subscriber's Birthdate ______________________________

Insurance Company ________________________________ Group No. __________________ Local No. ___________________

Insurance Co. Address ____ Phone _____________________________________

Primary Medical Coverage (For TMJ patients)

Subscriber's Name ____ Subscriber's SS No. or Alt ID ________________________

Subscriber's Birthdate ____________________ Patient relationship to subscriber _______Self ________Child _____Spouse

Employer Name and Address ____ Employer Phone ___________________

Insurance Company Name ____ Group No. _________________________

Medical Claim Billing Address ____ Phone ___________________________

City/State ____ Zip _______________________________________

INSURANCE ASSIGNMENT AND RELEASE – I, the undersigned assign directly to MOSHIRI ORTHODONTICS all insurance benefits, otherwise payable to me for services rendered.

I also hereby authorize MOSHIRI ORTHODONTICS to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

FINANCIAL RESPONSIBILITY – I understand that I am financially responsible for all charges whether or not paid by insurance. I am aware of the financial policies regarding patient services, payment and insurance assignment if applicable.

I understand that, where appropriate, credit bureau reports may be obtained.

Signature of Responsible Party (Parent's signature if minor) _________________________________ Date _______________

Please present your insurance card so that copies can be made. The benefits obtained from your carrier may be subject to change.

Medical and Dental History

Please circle Yes or No (if Yes, please fill in details)

Yes No Are you taking any medication(s)? List ______
Yes No Is antibiotic required prior to dental work? ______
Yes No Are you allergic to any medication (s)? List ______
Yes No Do you have a history of a major illness? ______
Yes No Are you currently under the care of a physician for a specific illness? ______
Yes No Have you had any major operations (if so, when)? ______

Check any of the following for which you have been treated?

— Colds	— Heart Problems	— Arthritis	— Herpes	— ADD/ADHD
— Sore Throats	— High Blood Pressure	— Gastrointestinal Disorders	— Immune Deficiency	— HIV/Aids
— Sinus Problems	— Rheumatic Fever	— Fainting/Dizziness	— Nervous Disorders	— Bone Disorders
— Ear Infections/Tubes	— Endocrine Problems	— Epilepsy	— Mental/Psychological Disorders	
— Allergies/Latex/Other	— Diabetes	— Tuberculosis	— Tumor/Cancer /Radiation/Chemotherapy	
— Asthma/Hay Fever	— Thyroid Problems	— Kidney Problems	— Hepatitis/Liver Problems	

What concerns you most about your teeth? ______

Desired Goals of Orthodontic treatment? ______

Please circle Yes or No (if Yes, please fill in details)

Yes No Have you or anyone in your family ever seen an orthodontist? If yes, who and when? ______
Yes No Have any other family members been treated in this office? ______
Yes No Have your wisdom teeth been removed? If, so when ______
Yes No Do you presently have any dental pain or sensitive to temperature or pressure? Explain ______
Yes No Do your gums bleed when you brush? Date of last cleaning appointment with general dentist ______
Yes No Are you a mouth breather? Yes No Do you have a snoring habit?
Yes No Have your tonsils and adenoids been removed? What age? ______
Yes No Have you had any type of thumb sucking/pacifier/nail biting or tongue habit? Until what age? ______
Yes No Do you have any speech problems? ______
Yes No Have there been any injuries to your face, mouth or teeth? Explain ______
Yes No Have there been any falling accidents or sport injuries? Explain ______
Yes No Have you been involved in any automobile accidents or received whiplash? Explain ______
Yes No Have you ever had sprained or broken bones? Explain ______
Yes No Do you get headaches? How many times per week? ______
Yes No Do you have facial or orbital pain? If so, where does it hurt? ______
Yes No Do you have jaw pain? Which side? ______
Yes No Do your teeth or jaws ever feel uncomfortable when you wake up in the morning?
Yes No Are you aware of clenching your teeth during the day or been told that you grind your teeth? ______
Yes No Do you have neck/shoulder/lower back pain?
Yes No Have you ever experienced chronic ringing or a feeling of fullness in your ears?
Yes No Do you have numbness in your fingers and/or toes?
Yes No Do you have clicking or popping of your jaw joints? Which? ______
Yes No Have you ever experienced open and/or closed lock? Explain ______
Yes No Have you ever had jaw and/or joint surgery? When? ______
Yes No Are you aware that some appointments will be during school/work hours? ______
If the patient is under age 16, height of parents. Mom ______ Dad ______ Patient ______

Female Patients only: Yes No Are you pregnant? Due Date ______

****Does the patient require antibiotic pre-medication for dental treatment? YES NO**

FARHAD MOSHIRI, D.M.D., M.S., P.C. and MAZYAR MOSHIRI, D.M.D., M.S., P.C.

777 S. New Ballas Rd., #116E

St. Louis, MO 63141

(314) 997-3999

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 obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

____

____

FARHAD MOSHIRI D.M.D., M.S., P.C. and MAZYAR MOSHIRI D.M.D., M.S., P.C.

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.

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 (04/14/03), 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 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 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 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. If you request copies, we will charge you $0.35 for each page, $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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.

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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

Contact Officer: **Farhad Moshiri, D.M.D., M.S., P.C. and Mazyar Moshiri, D.M.D, M.S., P.C.**

Telephone: 314-997-3999 ***Fax: 314-997-7554*** ***E-mail: info@smilesaintlouis.com***

Address: 777 S. New Ballas Rd Suite 116E, St. Louis, MO 63141

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).