WELCOME

Thank you for selecting Dr. Kohli's dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

PLEASE PRINT

PERSONAL INFORMATION **DATE _____**

Name _____ Date of Birth _____ Marital Status _____

Social Security_____ Sex_____ Tel_____

Address_____ City/State_____ Zip_____

Place of Employment _____ Tel _____

Occupation _____ Recommended by _____

Have You Ever Seen One Of Our Advertisements? _____Where? _____

Name of Physician _____Tel _____

Under Physician's Care Now? Yes / No Nature of Treatment _____

Reason For Today's Visit _____

Date of Last Dental Visit _____

Method of Payment:

Cash _____ Mastercard _____

Visa _____ American Express _____

Signature_____

Please allow us to make a copy of your photo I.D.

Payment is Due When Services Are Rendered.

Thank You For Your Cooperation.

WELCOME

PATIENT'S NAME: _____DATE: _____

PATIENT MUST CIRCLE YES OR NO TO ANSWER EACH QUESTION

Are you presently under a physician's care for any illness or problem? NO YES_____
Have you ever had any surgery? _____NO YES_____
Did you have General Anesthesia? _____NO YES_____
Have you ever had any unusual bleeding after surgery? _____NO YES _____
Have you ever had a serious injury to the head or neck? _____NO YES_____
Have you ever had any unusual bleeding after extraction of teeth? _____NO YES_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?:

Artificial Joints _____NO YES_____
Rheumatic Fever _____NO YES_____
Rheumatic Heart Disease _____NO YES_____
Congenital Heart Disease _____NO YES_____
Heart Murmur or MVP _____NO YES_____
Heart Trouble _____NO YES_____
Stomach or Intestinal Disease _____NO YES_____
Stroke _____NO YES_____
Emphysema, Asthma, or other Lung Disease _____NO YES_____
Diabetes _____NO YES_____
Cancer, Tumor, or Growths _____NO YES_____
Chemotherapy or Radiation _____NO YES_____
Hepatitis _____NO YES_____
Venereal Disease _____NO YES_____
Liver or Kidney Disease _____NO YES_____
A Positive HIV (AIDS) Test _____NO YES_____
Blood Pressure Problem _____NO YES_____
Arthritis or Rheumatism _____NO YES_____
Glaucoma _____NO YES_____
Other Serious Illness or Injury _____NO YES_____
Are you allergic to any drugs? _____NO YES_____
Have you ever had any unusual reaction to a drug? _____NO YES_____
Are you taking blood thinner? _____ _____NO YES_____
Date and location of last Protime (Blood Test) _____NO YES_____
Do you use aspirin? _____NO YES_____
Do you smoke? _____NO YES_____
Are you wearing contact lenses? _____NO YES_____
Do you have a cough or cold? _____NO YES_____
Are you pregnant or nursing a baby? _____NO YES (Female)
Are you taking birth control pills? _____NO YES (Female)
Are you taking any medications now? List. _____NO YES
_____
Any other important information we should know about your health? NO YES
List

To The Best Of My Knowledge The Foregoing Questions Have Been Accurately Answered.

PATIENT'S SIGNATURE: _____DATE _____

GENERAL DENTISTRY INFORMED CONSENT

Patients Name _____ Date _____

1. EXAMINATION/CONSULTATION

I am having the above treatment done. Dr. Kohli is not responsible for any existing dentistry prior to treatment at this office such as loose fillings, crowns, etc.

(Initials _____)

2. WORK TO BE DONE

I understand that I am having the following work (done: Cleaning__ , Fillings Bridges Crowns. Extractions Impacted teeth removed I.V. Sedation_, Nitrous Oxide Root Canals Reline Repair X-rays Other

(Initials _____)

3. DRUGS AND MEDICATION

I understand that antibiotics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Local anesthesia can sometimes cause injury to the nerve underlying the teeth resulting in numbness or tingling of the lip, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months, r in remote instances, permanently.

(Initials _____)

4. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examinations, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make all any changes and additions as necessary,

(Initials _____)

5. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, ect.), and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #4. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. **I** understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parasthesis) that can last for an indefinite period of time (days or months) or a fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost which is my responsibility.

(Initials _____)

6. CROWNS, BRIDGES, AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns which may come off easily and that I may be careful to ensure that they are kept on until the

permanent crowns are delivered. I realize the final changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

(Initials _____)

7. DENTURES - COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes to my new denture will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the denture fee.

(Initials _____)

8. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment. I understand that occasionally metal objects are cemented in the tooth or extended through the root which does not necessarily affect the success of the treatment. I understand that occasionally addition surgical procedures may be necessary following root canal treatment (apicoectomy).

(Initials _____)

9. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement, and/or extraction's. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials _____)

10. REPAIR

I understand that repairs are sometimes a form of compromised care and cannot be guaranteed.

(Initials _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I understand that no other Dentist other than the treating Dentist is responsible for my treatment.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

DATE_____

DOCTOR_____ WITNESS_____

Dr. Sutinder S. Kohli, B.D.S., M.S.

General Family Dentistry-

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 (04114/03), 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 fined 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 $0.50 for each page, $20 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 fast 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: Deep Kohli

Telephone: 386-255-8866 Fax: 386-255-0710

E-mail:

Address: 484 S. Ridgewood Avenue Suite, Daytona Beach. FL 32114

Dr. Sutinder S. Kohli, B.D.S., M.S.
General Family Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____Social Security Number: _____

SECTION B: TO THE PATIENT_PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities. and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting

Contact Person: Deco Kohli

Telephone: 386-255-8868 Fax: 386-255-0710

Address: 464 S. Ridgewood Avenue: Suite 3: Daytona Beach. FL 32114

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent

SIGNATURE

I _____ have had full opportunity to read and consider the contents of this Consent

form and your Notice of Privacy Practices. l understand that, by signing this Consent form, 4 am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

SIGNATURE: _____Date: _____

lf this Consent is signed by a personal representative on behalf of the patient, complete the following

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent_

SIGNATURE: _____Date: _____

Dr. Sutinder S. Kohli B.D.S., M.S.

General Family Dentistry

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:

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

_____

_____

_____

LEGAL GUARDIAN RELEASE

Patient's Name: _____

I, the undersigned legal guardian / parent, of a minor child, acknowledge and hereby grant permission to Dr. Sutinder S. Kohli, his agents, and employees to render professional services for my child.

Date:_____

Guardian's / Parent's Name: _____

Employee verifying call: _____

Guardian's / Parent's Signature: _____

Witness: _____