

---

HAGOPIAN & BOGHOSIAN, 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 April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. 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 authorize 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 \$0.25 for each page, \$20.00 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: John Hagopian

Telephone: 847-692-7760

Fax: 847-692-2264

E-mail: [info@hb-dentistry.com](mailto:info@hb-dentistry.com)

Address: 101 S Washington Ave., Suite 135, Park Ridge , Il 60068

© 2002 American Dental Association  
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

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



# HAGOPIAN & BOGHOSIAN DENTISTRY

## New Patient Registration

TODAY'S DATE	_____			
LAST NAME	_____ FIRST NAME	_____ DATE OF BIRTH	_____	
STREET ADDRESS	_____ CITY	_____ STATE	_____ ZIP	_____
EMAIL	_____ SOCIAL SECURITY #	_____		
PHONE # (HOME)	_____ (CELL)	_____ (WORK)	_____	
IF PATIENT IS A CHILD, PARENT/GUARDIAN INFORMATION:				
LAST NAME	_____ FIRST NAME	_____ DATE OF BIRTH	_____	
SOCIAL SECURITY #	_____ PHONE #	_____ EMAIL	_____	
ADDRESS, IF DIFFERENT THAN CHILD	_____			
_____				

NAME OF INSURED	_____ DATE OF BIRTH	_____	
ID #	_____ GROUP #	_____	
INSURED'S STREET ADDRESS	_____ CITY	_____	
STATE	_____ ZIP	_____ RELATIONSHIP TO PATIENT	_____
INSURANCE PLANE NAME, PHONE AND ADDRESS	_____		
_____			

### CONSENT FOR TREATMENT

1. I HEREBY AUTHORIZE DOCTOR OR DESIGNATED STAFF TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, AND OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF ( NAME OF PATIENT) \_\_\_\_\_'S DENTAL CONDITION..
2. UPON SUCH DIAGNOSIS, I AUTHORIZE DOCTOR TO PERFORM ALL RECOMMENDED TREATMENT MUTUALLY AGREED UPON BY ME AND EMPLOY SUCH ASSISTANCE AS REQUIRED TO PROVIDE PROPER CARE.
3. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. IN THE EVENT PAYMENTS ARE NOT RECEIVED BY AGREED UPON DATES, I UNDERSTAND THAT A 1-1/2% LATE CHARGE (18% APR) MAY BE ADDED TO MY ACCOUNT. IF REQUIRED, I ALSO UNDERSTAND A CHECK OF MY CREDIT HISTORY MAY BE MADE.

SIGNATURE OF PATIENT, PARENT or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# HAGOPIAN & BOGHOSIAN DENTISTRY

## Dental History

PATIENT NAME \_\_\_\_\_

WHAT IS THE REASON FOR YOUR VISIT TODAY? \_\_\_\_\_

DATE OF LAST DENTAL VISIT \_\_\_\_\_ LAST DENTAL CLEANING \_\_\_\_\_ LAST FULL MOUTH X-RAY \_\_\_\_\_

PREVIOUS DENTIST'S NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

EMAIL \_\_\_\_\_ ADDRESS \_\_\_\_\_

HOW OFTEN DO YOU BRUSH YOUR TEETH? \_\_\_\_\_ HOW OFTEN DO YOU FLOSS? \_\_\_\_\_

DO YOU USE ANY OTHER DENTAL HOME CARE PRODUCTS? \_\_\_\_\_

DO YOU HAVE ANY DENTAL PROBLEMS NOW? IF SO, DESCRIBE: \_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR CURRENTLY HAVE:**

----SENSITIVE TEETH (HOT/COLD/SWEETS)

----ORTHODONTIC TREATMENT

----SENSITIVE TO SWEETS

----ORAL SURGERY

----SENSITIVE TO BITING

----RADIATION THERAPY TO HEAD/NECK

----BAD BREATH

----PERIODONTAL TREATMENT

----BLEEDING/SORE GUMS

----INJURY TO THE MOUTH/HEAD

----MOUTH GUARD

----CLENCHING/GRINDING

----FREQUENT BLISTERS/COLD SORES

----CLICKING/POPPING JAW

----HEADACHES

----PAIN (JOINT, EAR, FACE)

----NECKACHES

----DIFICULTY IN OPENING OR CLOSING

----LOOSE TEETH

----DIFICULTY IN CHEWING

----SMOKE/CHEW TOBACCO

**PLEASE RATE: (1-5, 5 BEING THE HIGHEST)**

1. ARE YOU SATISFIED WITH YOUR TEETH'S APPEARANCE? \_\_\_\_\_
2. WOULD YOU LIKE TO KEEP ALL OF YOUR TEETH ALL OF YOUR LIFE? \_\_\_\_\_
3. DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? \_\_\_\_\_

**IS THERE ANYTHING ELSE ABOUT HAVING DENTAL TREATMENT THAT YOU WOULD LIKE US TO KNOW? IF SO, DESCRIBE:**

# HAGOPIAN & BOGHOSIAN DENTISTRY

## Medical History

PRIMARY PHYSICIAN'S NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

LIST ANY MEDICATIONS, NOTING REASON, DOSAGE AND FREQUENCY \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DO YOU HAVE ANY DRUG ALLERGIES? \_\_\_\_\_ IF SO, PLEASE LIST: \_\_\_\_\_

\_\_\_\_\_

FEMALES: ARE YOU PREGNANT? \_\_\_\_\_ DUE DATE \_\_\_\_\_

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE HAD OR CURRENTLY HAVE:

----AIDS/HIV POSITIVE

----CONG. HEART DISORDER

----LEUKEMIA

----ALZHEIMER'S

----DIABETES

----LIVER DISEASE

----ANAPHYLAXIS

----DRUG ADDICTION

----LUNG DISEASE

----ANEMIA

----EPILEPSY OR SEIZURES

----MITRAL VALVE PROLAPSE

----ANGINA

----EXCESSIVE BLEEDING

----OSTEOPOROSIS

----ARTHRITIS/GOUT

----FAINTING/DIZZINESS

----PSYCHIATRIC CARE

----ARTIFICIAL HEART VALVE

----GLAUCOMA

----RADIATION TREATMENT

----AUTISM

----HEART PROBLEMS/DISEASE

----RHEUMATIC FEVER

----ARTIFICIAL JOINT

----HEPATITIS A

----SHINGLES

----ASTHMA

----HEPATITIS B or C

----SINUS TROUBLE

----BLOOD DISEASE

----HIGH BLOOD PRESSURE

----STROKE

----CANCER

----HIGH CHOLESTEROL

----THYROID DISEASE

----CHEMOTHERAPY

----HIVES or RASH

----TUBERCULOSIS

----CHEST PAINS

----HYPOGLYCEMIA

----TUMOR or GROWTHS

----KIDNEY PROBLEMS/DISEASE

----ULCERS

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR THE PATIENT'S) HEALTH. I UNDERSTAND, IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT or GUARDIAN

\_\_\_\_\_  
DATE

**HAGOPIAN & BOGHOSIAN DENTISTRY**

**Acknowledgement of Receipt of Notice of Privacy Practices**

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

I, (Print Name) \_\_\_\_\_ have received a copy of this office's Notice of

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

---- COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT

---- OTHER (PLEASE SPECIFY) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_