NINA KUMAR DDS

PREVENTIONDETECTION**INTERVENTION**

Here at Nina Kumar, DDS, we strive to provide our patients with optimal care in a warm & comforting environment. We practice preventive dentistry, but also focus on caring for acute and chronic dental needs. We do our best to achieve early detection, early intervention, & prevention, and we hope to instill the same philosophy in our patients. Regularly scheduled office visits allow us to better assist you by identifying and managing potential dental issues more efficiently.

Being proactive about your dental health can often help you prevent and/or prolong the onset of future problems. We firmly believe, and our experience has shown it to be true, that those patients who are consistent in keeping their appointments have fewer episodes, less difficulty with unstable chronic dental problems, and generally continue to enjoy better health overall.

As a general dental office, we provide a spectrum of services including everything from examinations and cleanings, to fillings, crowns, bridges, dentures, implant dentistry, Invisalign, whitening, emergency care, treatment of tempromandibular joint dysfunction (TMD), oral cancer screening, and much more. Dr. Kumar and her staff are committed to doing everything possible to provide you with excellent dental care. Our practice is truly a family practice that is based on word-of-mouth referrals. To us, a referral is the best kind of compliment. We hope to build the kind of relationships with our patients that facilitate recommending us to friends and family.

NINA KUMAR DDS

Notice of Privacy Policy 1/2

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 November 17. 2009. 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.

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 9/10/2009, 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.

NINA KUMAR DDS

Notice of Privacy Policy 2/2

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 $150 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 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.

NINA KUMAR DDS

patient info

PATIENT**INFORMATION**

LastName: _____ **First**Name:_____**MI**:_____

PreferredName: _____ DOB: ___/____/_____

✶Contact Information✶

ADDRESS: _____

_____

CITY: _____ STATE: ____ ZIP: _____

Email: _____

Phone: (please ✓preferred) ☐ cell: ___-____-_____ ☐ work: ___-____-_____

SOCIAL**NETWORKING** *optional

@ _____

@ _____

*follow us @ninakumardds for news & updates!

insuranceinfo

PATIENT IS: ☐ Patient ☐ Responsible Party ☐ Policy Holder

Have you used this insurance before today? ☐ YES ☐ NO

Relationship to Policy Holder: _____

Policy Holder *(if not self)*:

First Name: _____ Last Name: _____ MI: _____

Policy Holder's DOB : ___/____/_____ SS#: ___-____-_____

Primary Insurance: _____ Policy #:_____

Employer: _____

Secondary Insurance: _____ Policy #:_____

Relationship to Policy Holder: _____

Last Name: _____ First Name:_____ MI: _____

Policy Holder's DOB(if not self): ___/____/_____ SS#: ____-____-_____

PATIENT**QUESTIONNAIRE**

How did you hear about us? _____

What initiated your visit? _____

When was your last dental visit? _____

Do you have any discomfort at this time? _____

How would you describe you comfort level in the dental chair? _____

How often do you brush _____

How often do you floss? _____

What do you consider your present state of dental health to be? ☐ Poor ☐ Good ☐ Excellent

How do you feel about the appearance of your mouth/smile? ☐ Poor ☐ Good ☐ Excellent

What, if anything, would you want to change about your smile? _____

Have you ever been treated for periodontal disease? _____
gum disease/pyorrhea/trench mouth

What are your goals concerning your dental health? _____

SPECIFIC MOUTH DISORDERS *Check all that apply*

☐ Bleeding &/or Sore Gums
☐ Unpleasant Taste/Bad Breath
☐ Burning Tongue/Lips
☐ Frequent Blisters Lip/Mouth
☐ Swelling/Lumps in Mouth
☐ Grinding Night/Day
☐ Biting Cheeks/Lips
☐ Clicking/Popping/Painful jaw
☐ Difficulty Opening/Closing Jaw

SPECIFIC TEETH DISORDERS *Check all that apply

☐ Loose Teeth
☐ Discomfort While Chewing
☐ Food Impaction
☐ Sensitivity to Sweet
☐ Swelling/Lumps in Mouth
☐ Breaking/Cracking of Teeth
☐ Sensitivity to Hot &/or Cold
☐ Shifting in Bite
☐ Discoloration of Teeth

ADDITIONAL COMMENTS/THOUGHTS:

_____

_____

MEDICAL HISTORY

Are you under a physicians care?	☐ YES ☐ NO	Please explain: _____
Have you ever been hospitalized or had a major operation?	☐ YES ☐ NO	Please explain: _____
Have you ever had a serious head or neck injury?	☐ YES ☐ NO	Please explain: _____
Are you Taking any medications?	☐ YES ☐ NO	Please explain: _____
Are you on a special diet?	☐ YES ☐ NO	Please explain: _____
Do you use/have you used tobacco?	☐ YES ☐ NO	Please explain: _____
Do you use any controlled substances?	☐ YES ☐ NO	Please explain: _____

WOMEN:

Pregnant/Trying to get pregnant? ☐ YES ☐ NO

Taking Oral Contraceptives? ☐ YES ☐ NO

Nursing? ☐ YES ☐ NO

ALLERGIES: ☐ YES ☐ NO

If yes, please explain:

☐ Penicillin ☐ Metal ☐ Aspirin

☐ Local Anesthetic ☐ Codeine ☐ Acrylic

☐ Latex ☐ Other:

DO YOU HAVE ANY OF THE FOLLOWING OR HAVE YOU HAD OF THESE CONDITIONS IN THE PAST?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Cough	☐ Hepatitis B or C	☐ Pain in Jaw Joints	☐ Spina Bifidus
☐ Alzheimer's Disease	☐ Cold Sore/Fever Blisters	☐ Frequent Diarrhea	☐ Herpes	☐ Parathyroid Disease	☐ Stomach/Intestinal Disease
☐ Anaphylaxis/ Shock	☐ Congenital Heart Disease	☐ Frequent Headaches	☐ High Blood Pressure	☐ Psychiatric Care	☐ Stroke
☐ Anemia	☐ Convulsions	☐ Genital Herpes	☐ Hives/Rash	☐ Radiation Therapy	☐ Swelling of Limbs
☐ Angina	☐ Cortisone Medicine	☐ Glaucoma	☐ Hypoglycemia	☐ Recent Weight Loss	☐ Thyroid Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Hay Fever	☐ Irregular Heart Beat	☐ Renal Dialysis	☐ Thyroid Disease
☐ Artlficial Heart Valve	☐ Drug Addiction	☐ Heart Attack/Failure	☐ Kidney Problems	☐ Rheumatic Fever	☐ Tonsillitis
☐ Artificial Joint	☐ Easily Winded	☐ Heart Murmur	☐ Leukemia	☐ Rheumatism	☐ Tuberculosis
☐ Asthma	☐ Emphysema	☐ Heart Pace Maker	☐ Liver Disease	☐ Scarlet Fever	☐ Tumors/Growths
☐ Blood Disorder	☐ Epilepsy/Seizures	☐ Heart Trouble/Disease	☐ Low Blood Pressure	☐ Shingles	☐ Ulcers
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hemophilia	☐ Lung Disease	☐ Sickle Cell Disease	☐ Venereal Disease
☐ Breathing Problems	☐ Excessive Thirst	☐ Hepatitis A	☐ Mitral Valve Prolapse	☐ Sinus Trouble	☐ Jaundice
☐ Cancer	☐ Chemotherapy	☐ Fainting Spells/ Dizziness	☐ Bruise Easily	☐ OTHER _____	

IF OTHER, PLEASE SPECIFY:

_____

_____

CANCELLTIONPOLICY

Here at the office of Dr. Nina Kumar, we do understand that in today's world, occasionally situations come up that are beyond your control. Keeping this in mind, we are asking that you extend the courtesy of adequate time to reschedule valuable appointment time that was reserved just for you. If you know that there may be an issues with your appointment time, the sooner you contact our office, the more effective we can be in allowing other patients the opportunity to fulfill their treatment needs. We ask that you give us 24 hour notice for appointments scheduled for an hour (or less) in duration, and an additional 24 hours (48 hours) for appointments in excess of an hour.

For individuals that do not comply with this request will be required to pay a cancellation fee of $150.

Chronic abusers of scheduled appointments and patients who have scheduling issues due to personal &/or work conflicts will be placed on the ASAP list and will be contacted as availabilities arise in the schedule.

By signing below, you are agreeing to the terms of this policy and understand and accept them.

Signature: _____ Date: ____/____/_____

Name: _____

informed consent

I understand that as a patient of Nina Kumar, DDS, I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that all information shared with the clinicians here are confidential and no information will be released without my consent. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at the office of Dr. Nina Kumar. I may discuss them with her.I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Nina Kumar, DDS. I understand that I may stop treatment at any time.

Signature: _____

Name: _____

Date: ____/____/_____

Notice of Privacy Practices

patient*acknowledgement*

Patient Name: _____

I have received and understand this Practice's Notice of Privacy Practices written in plain language. This notice provides in details the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information.

This practice reserves the right to change the terms of its Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____

Date: ____/____/_____