Notice of

Privacy Policy And Practices

Adnan Qayyum, DDS LLC
65 E. Elizabeth Ave.
Suite 504
Bethlehem, PA 18018
610-868-1322

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice

Our office respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This notice describes our privacy practices with respect to our health information. Our privacy practices apply to current and former patients.

Types of Personal and Health Information We Collect

We collect a variety of personal and health information when delivering health care. You provide some of this information, when you initially come into office (such as address, Social Security number, and health history). We also receive additional personal and health information (such as eligibility) through our transaction with employers, insurance companies, and other health care providers. We limit the collection of personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements.

How We Protect Personal and Health Information

We treat personal and health information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide services to patients (for example, our billing clerks and medical assistants). These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law. We meet physical, electronic and procedural security standards to protect personal and health information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal and Health Information

We may share any of the personal and health information we collect (as described above) with our associates as permitted by law. We may also

Disclosure of Personal and Health Information (continued)

disclose this information to non-associated entities or individuals as permitted or required by law. Non-associates with whom we may disclose information as permitted by law include our attorneys, accountants and auditors, a patient's authorized representative, other health care providers, public health authorities, coroners, medical examiners, and funeral directors, organ donation organizations, Institutional Review Boards for research purposes, third party administrators, insurers, and law enforcement or regulatory authorities. We may also disclose any of the personal and health information we collect (as described above) in order to provide appointment reminders or to give you information about other treatments or health related benefits and services that may be of interest to you. In addition, in the event that this office is sold or merged with another office, your personal and health information will become the property of the new owner. We do not disclose personal or health information to any other third parties without a patient's request or authorization.

Individual Rights To Access & Correct Personal & Health Information

We have procedures for a patient to access the personal and health information we collect, and other than information we collect in connection with, or in anticipation of, a lawsuit or legal claim, we will make this information available to the patient upon written request.

Our goal is to keep our patient information up-to-date and to correct inaccurate information. We have procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. If you believe that any personal or health information we have about you is not accurate, please let us know by contacting our Office Manager.

Further Information

The practice reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, the practice is required by law to comply with this Notice.

<u>Adnan Qayyum, DDS LLC</u>

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE

I acknowledge that I have received the Notice of Privacy Policy and Practices for Adnan Qayyum, DDS.

____

Printed Name (Patient/Parent/Guardian/Representative)

____________________________________ ________________

Signature (Patient/Parent/Guardian/Representative) **Date of Receipt**

In case of Parent/Guardian/Representative of patient

____

Relationship to Patient (or other authority)

<u>Adnan Qayyum, DDS LLC</u>

<u>*Composite Restorations (Tooth Color Fillings)*</u>

Dear Valued Patient:

Dr. Qayyum's office uses white filling material routinely to restore teeth. We prefer to use this material for esthetic reasons, (being white as opposed to silver or gray). It is a composite material which can be chemically bonded to the tooth for strength and ease of repair.

Some insurance companied pay a percentage of these restorations, and some pay nothing at all. In most cases, they will pay a percentage or only pay the fee they allow for amalgam (silver or gray) restorations.

I, the Patient, ____________________________, agree to pay any unpaid balance for the procedure regardless of Dr. Qayyum's participation with my insurance plan.

Patient Signature ____

Office Personnel ____

Adnan Qayyum, DDS

Medical History

1. Are you having pain or discomfort at this time? ☐ Yes ☐ No

2. Please list your Medical Doctor's information below:

   Physician's Name: ____________________ Phone Number: ____________

   Address: ____

3. Are you now taking any medication, drugs, or pills? ☐ Yes ☐ No

   If yes, please list: ____

4. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? ☐ Yes ☐ No

   If yes, please list: ____

5. Indicate which of the following you have had or have at present. Check "yes" or "no" to each item:

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
Heart Failure	☐ Yes ☐ No	Kidney Trouble	☐ Yes ☐ No	Hepatitis C	☐ Yes ☐ No
Heart Disease or Attack	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Angina Pectoris	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	A.I.D.S.	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	H.I.V. Positive	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No	Cold Sores/Fever Blisters	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Blood Transfusions	☐ Yes ☐ No
Arteriosclerosis	☐ Yes ☐ No	Cosmetic Surgery	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Chronic Cough	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Heart Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No
Heart Surgery	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Allergies or Hives	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No	Fainting or Dizzy Spells	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Chemotherapy	☐ Yes ☐ No	Nervousness	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Hepatitis A (infectious)	☐ Yes ☐ No	Psychiatric Treatment	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No	Developmentally Disabled	☐ Yes ☐ No

6. Has your medical doctor ever said you have a cancer or tumor? ☐ Yes ☐ No

7. Do you have or have you had any disease, condition, or problem no listed? ☐ Yes ☐ No

   If yes, please list: ____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No If yes, what month? ____________

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½ % finance charge (18% APR) may be added to my account.

Patient / Responsible Party ____________________ **Date** ____________ **Witness** ____________

Adnan Qayyum, DDS

Dental History

When was your last dental visit? ____ Months ______ years

Reason for leaving last dentist? ______________________________

When was you last dental cleaning? ____ Months ____ years

How often do you brush your teeth? ____ Times per day

How often do you floss? _____ Day _____ week _____ month _____ rarely

Does it tear when you floss? ☐ Yes ☐ No

Do you have any broken teeth? ☐ Yes ☐ No

Do you use any tobacco products? ☐ Yes ☐ No

Have you ever had braces? ☐ Yes ☐ No If yes, when? ______________________________

Have you had your wisdom teeth out? ☐ Yes ☐ No If yes, when? ______________________________

How old are you? _____

Do your gums bleed when you brush or floss? ☐ Yes ☐ No

Do you get food packed between your teeth? ☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you have sensitive teeth? ☐ Yes ☐ No

Do you have any discomfort? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

If you could change your smile what would you like to do? ______________________________

____

Do you have any concerns not mentioned? ______________________________

____

Adnan Qayyum, DDS

Thank you for your visit today. We appreciate you trusting us to care for your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask - - we will be glad to help. We look forward to working with you.

Patient Information

Appointment Preference: ☐ Morning ☐ Afternoon

Date of Birth: ____________________

Name you prefer to be called by: ____________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Legal Name: ____________________

Lives with: ____________________

Address: ____________________

Full Time Student: ☐ Yes ☐ No

City, State, Zip: ____________________

School: ____________________

Home Phone: ____________________

Grade: ____________________

Work Phone: ____________________

SSN of person seeing us today: ____________________

E-mail: ____________________

Do you need pre-medication before treatment? ☐ Yes ☐ No

Pager: ____________________

Other family members seen by us: ____________________

Cell Phone: ____________________

Who may we thank for referring you here? ____________________

Fax Number: ____________________

In case of emergency who should be notified: ____________________

Emergency contact phone: ____________________

Person Responsible for this Account

Name: ____________________

Date of Birth: ____________________

Address: ____________________

SSN: ____________________

City, State, Zip: ____________________

Employer: ____________________

Home Phone: ____________________

Cell Phone: ____________________

Work Phone: ____________________

Fax Number: ____________________

E-mail: ____________________

Driver's License #: ____________________

Insurance Information

Employer: ____________________

Occupation: ____________________

Address: ____________________

Insurance Co. ____________________

City, State, Zip: ____________________

Insurance Phone: ____________________

Plan Name: ____________________

Plan Number: ____________________

Employee: ____________________

SSN: ____________________

Date of Birth: ____________________

Adnan Qayyum, DDS LLC

Our primary goal at our office is to establish long-term, caring relationships with our patients. Dr.Qayyum accepts all major dental insurance. Understanding your insurance coverage can be quite challenging. You will be expected to pay your estimated portion at the time of your visit. We will file your claim electronically with your insurance carrier. Please be aware that we are only capable of approximating your portion of the payment. Insurance companies periodically change benefits without notifying each dental office of these changes. Therefore, this office can only estimate your insurance reimbursement. Remember that no insurance company attempts to cover all dental costs.

Payment Options

1. Cash - This includes money orders and personal checks.

2. Visa/MasterCard/Discover - We accept credit cards as payment for treatment to

the extent your credit limit permits.

3. City Health Care - This option offers a separate line of credit to cover your entire

family's health care needs.

A credit line can be established and approval usually takes less than 10 minutes online or over the phone.

City Health Care has an interest free option.There is no annual membership fee. The payments are made at a minimum interest on a monthly basis.

I hereby authorize Dr. Qayyum and his staff to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Qayyum. I understand I am responsible for any unpaid

balance.

____

Signature of Patient/Insured

____

Date

Your Child's Dental History

Date of last visit to dentist ____________________ Child's age ________________________________

What service did child have done ____

Has child complained about dental problems ____

Any unhappy dental experiences ____

Any injuries to mouth - teeth or head ______________________________________

Any mouth habits – thumb sucking – nail biting – mouth breathing – nursing bottle habits- pacifier etc.

____

Any unusual speech habits ____

Any lost teeth ____

Have missing teeth been replaced ____

Orthodontic appliances worn now or ever been worn ____________________________________

Does your child brush teeth daily ____________________ How often ____________________

Do you assist child when tooth brushing ____

Is dental floss used ____________________ How often ____________________

Are disclosing tablets used ____________________ How often ____________________

Is fluoride taken in any form ____

Do you have any concerns you would like us to know about ______________________________

____

What is your child's favorite…

Sport ____

Toy ____

Hobby ____

Person ____

Movie ____

Character ____

Color ____