



12620 Clarksville Pike (Route 108)  
 Clarksville, MD 21029  
 Phone: (410) 531-5639  
 Fax: (410) 531-6625  
 www.ParmarDMD.com

### 1. PATIENT INFORMATION

|  |                                  |                                    |                                   |
|--|----------------------------------|------------------------------------|-----------------------------------|
| Name: _____  |                                  | SS# _____                          | Date: _____                       |
| First Name   | Last Name                        |                                    |                                   |
| Address: _____   |                                  |                                    |                                   |
| City: _____  |                                  | State: _____                       | Zip: _____                        |
| Wish to be Called: _____                                   |                                  | Responsible Party: _____           |                                   |
|  |                                  | Name/Relationship                  |                                   |
| Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Birth Date: _____                |                                    | Age: _____ years                  |
| <input type="checkbox"/> Married                           | <input type="checkbox"/> Widowed | <input type="checkbox"/> Single    | <input type="checkbox"/> Minor    |
|  |                                  | <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced |
| Occupation: _____  |                                  | Employer / School Phone: _____     |                                   |
| Employer/School Address: _____                             |                                  |                                    |                                   |
| Spouse's Name: _____                                       |                                  | Spouse's Birth Date: _____         | Spouse's SS# _____                |
| Spouse's Employer/Address: _____                           |                                  |                                    |                                   |
| How did you hear about our office? _____                   |                                  |                                    |                                   |

### 2. INSURANCE INFORMATION - DENTAL

|  |                                |                         |
|--|--------------------------------|-------------------------|
| Subscriber's Name: _____   | Subscriber's Birth Date: _____ | Subscriber's SS# _____  |
| Relationship to Patient: _____   |                                |                         |
| Insurance Company: _____   |                                | Ins. Comp. Phone: _____ |
| Policy/Group # _____   | Insurance Comp. Address: _____ |                         |
| Is there any additional dental insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No |                                |                         |

### INSURANCE INFORMATION – MEDICAL

|                                |                                |                         |
|--------------------------------|--------------------------------|-------------------------|
| Subscriber's Name: _____       | Subscriber's Birth Date: _____ | Subscriber's SS# _____  |
| Relationship to Patient: _____ |                                |                         |
| Insurance Company: _____       |                                | Ins. Comp. Phone: _____ |
| Policy/Group # _____           | Insurance Comp. Address: _____ |                         |

### ASSIGNMENT AND RELEASE

I understand that Dr. Parmar does not participate with many insurance companies and that reimbursements will come either to the office or to me directly depending on your insurance contract. Regardless of where the reimbursements go, I will be responsible for any and all charges for all work done and/or all services provided by Dr. Parmar and her office.

Dr. Parmar may use my healthcare information and may disclose such information to insurance companies and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits for related services.

Signature of Patient, Parent, Guardian or Personal Representative: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_



|  |  |
|--|--|
| Do you use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If Yes, what and how often, how long? _____   |  |
| Do you use antidepressants or sleeping pills? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes, list name(s) _____   |  |
| <input type="checkbox"/> <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> <input type="checkbox"/> C Pap  | <input type="checkbox"/> <input type="checkbox"/> Have you had sleep Studies <input type="checkbox"/> <input type="checkbox"/> Have you seen ENT         |
| <input type="checkbox"/> <input type="checkbox"/> Do you snore <input type="checkbox"/> <input type="checkbox"/>   | <input type="checkbox"/> <input type="checkbox"/> Have you seen chiropractor <input type="checkbox"/> <input type="checkbox"/> Have you seen neurologist |
| Are you on any blood thinners, including Asprin? <input type="checkbox"/> Yes    Mg <input type="checkbox"/> No  |  |
| Are you currently taking or have taken any of the following medications?   |  |
| <b>Yes</b> <b>No</b>   | <b>Yes</b> <b>No</b> <b>Yes</b> <b>No</b>  |
| <input type="checkbox"/> <input type="checkbox"/> Alendromate-Fosomax-oral   | <input type="checkbox"/> <input type="checkbox"/> Ibandrote-Boniva-oral <input type="checkbox"/> <input type="checkbox"/> Tiludronate-Skelid-oral        |
| <input type="checkbox"/> <input type="checkbox"/> Clodronate-Ostac, Bonefos-IV & oral  | <input type="checkbox"/> <input type="checkbox"/> Pamidronate-Aredia-IV <input type="checkbox"/> <input type="checkbox"/> Zoledronic acid – Zometa-IV    |
| <input type="checkbox"/> <input type="checkbox"/> Etidronate-Didronal-IV and oral  | <input type="checkbox"/> <input type="checkbox"/> Risedronate-Actonel-oral <input type="checkbox"/> <input type="checkbox"/> Other                       |
| Women: Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes, when is your due date? _____  |  |
| Taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Are you taking hormones? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| <b>MEDICATIONS</b>   | <b>Are you allergic to?</b>  |
| List any medications you are currently taking and the correlating diagnosis  | <input type="checkbox"/> Aspirin <input type="checkbox"/> Latex <input type="checkbox"/> Penicillin  |
| <input type="checkbox"/> Vitamins / Minerals <input type="checkbox"/> Herbs  | <input type="checkbox"/> Codeine <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> None   |
| Pharmacy Name: _____ Phone: _____  | <input type="checkbox"/> Lodine <input type="checkbox"/> Sulfa <input type="checkbox"/> Other  |
|  | <input type="checkbox"/> Barbiturates (Sleeping pills) <input type="checkbox"/> _____  |
| 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. I understand that it is my responsibility to advise your office of any changes in the information contained in this form. |  |
| Patient/Parent/Guardian Signature: _____ Date: _____   |  |

#

## TMJ Questionnaire

What are the chief complaints for which you are seeking treatment?

| ORDER   | FREQUENCY  | INTENSITY   |
|---|--|---|
| Please rate your chief complaints by number:<br><b>#1</b> – being the most important<br><b>#2</b> – the 2 <sup>nd</sup> most important<br><b>#3</b> – 3 <sup>rd</sup> important,<br><b>#4, #5, #6...</b> etc. (List all please) | Rate your chief complaints for frequency as follows:<br>1 = Seldom<br>2 = Occasional<br>3 = Frequent<br>4 = Everyday | Rate the intensity of each complaint on a scale from 1 to 10.<br>0 = No pain<br>10 = Most severe pain |

| Chief Complaint           | ORDER | FREQUENCY<br>1 – 4 | INTENSITY<br>0 – 10 |
|---------------------------|-------|--------------------|---------------------|
| Jaw clicking / popping    | _____ | _____              | _____               |
| Jaw joint noises          | _____ | _____              | _____               |
| Jaw locking               | _____ | _____              | _____               |
| Jaw pain                  | _____ | _____              | _____               |
| Muscle twitching/soreness | _____ | _____              | _____               |
| Limited mouth opening     | _____ | _____              | _____               |
| Dizziness                 | _____ | _____              | _____               |
| Headaches                 | _____ | _____              | _____               |
| Visual disturbances       | _____ | _____              | _____               |
| Facial pain               | _____ | _____              | _____               |
| Ear pain                  | _____ | _____              | _____               |
| Back pain                 | _____ | _____              | _____               |
| Eye pain                  | _____ | _____              | _____               |
| Neck pain                 | _____ | _____              | _____               |
| Pain when chewing         | _____ | _____              | _____               |
| Throat pain               | _____ | _____              | _____               |
| Ear congestion            | _____ | _____              | _____               |
| Sinus congestion          | _____ | _____              | _____               |
| ringing in the ears       | _____ | _____              | _____               |
| Fatigue                   | _____ | _____              | _____               |

Patient Initials: \_\_\_\_\_

Date: \_\_\_\_\_

.....because your smile matters.

#

#

**SYMPTOMS:** Please indicate location and type of any head pain

L=Left, R=Right, B=Both

| HEAD PAIN | LOCATION                      | SEVERITY                 |                          |                                    | FREQUENCY                |                            |                          | DURATION                 |                          |                          |
|-----------|-------------------------------|--------------------------|--------------------------|------------------------------------|--------------------------|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|           |                               | Moderate                 |                          | Occasional<br>(Monthly<br>or Less) | Frequent<br>(Weekly)     | Constant<br>(Every<br>Day) | Minutes                  |                          | Days                     |                          |
|           |                               | Mild                     | Severe                   |                                    |                          |                            | Seconds                  | Hours                    | Weeks                    |                          |
| L R B     | Front of your head (Frontal)  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L R B     | Entire head (Generalized)     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L R B     | Top of your head (Parietal)   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L R B     | Back of your head (Occipital) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L R B     | In your temples (Temporal)    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>           | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**HISTORY OF SYMPTOMS**

When did your condition first occur? \_\_\_\_\_

What do you believe to be the cause of your pain or condition? \_\_\_\_\_

- |  |   |
|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Motor vehicle accident | Y <input type="checkbox"/> N <input type="checkbox"/> Playground incident |
| Y <input type="checkbox"/> N <input type="checkbox"/> Motorcycle accident    | Y <input type="checkbox"/> N <input type="checkbox"/> Athletic endeavor   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Work related accident  | Y <input type="checkbox"/> N <input type="checkbox"/> Fight               |
| Y <input type="checkbox"/> N <input type="checkbox"/> Fall                   | Y <input type="checkbox"/> N <input type="checkbox"/> Injury              |
| Y <input type="checkbox"/> N <input type="checkbox"/> Accident               | Y <input type="checkbox"/> N <input type="checkbox"/> Unknown             |
| Y <input type="checkbox"/> N <input type="checkbox"/> Illness                | Y <input type="checkbox"/> N <input type="checkbox"/> _____               |

If accident, what was the date? \_\_\_\_\_

What other information is important to your pain or condition? \_\_\_\_\_

**DRAW YOUR PAIN PATTERNS FOLLOWING THE KEY AT THE BOTTOM:**

|               |       |  |
|---------------|-------|--|
| Mild Pain     |       |  |
| Moderate Pain | ΛΛΛ   |  |
| Severe Pain   | ///// |  |

B=Burning, D=Dull, N=Numbing, P=Pressure, S=Sharp, T=Tingling, R=Radiating

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



12620 Clarksville Pike (Route 108)  
Clarksville, MD 21029  
Phone: (410) 531-5639  
Fax: (410) 531-6625  
www.ParmarDMD.com

### SNORING – SLEEP AND APNEA HISTORY

| Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you become easily fatigued? At what time of day? _____                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have problems with insomnia? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you sleep well? How long? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | On waking up – given an opportunity, could you sleep for another hour or two? _____           |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you dream? How often? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have trouble falling asleep or staying asleep? Which? _____                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you snore or have you been told you do?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wake-up with a headache?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had chronic sleepiness, fatigue or weariness that you cannot explain?                |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you often fall asleep reading or watching TV?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you fallen asleep during the day against your will?                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had to pull off the road while driving due to sleepiness?                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been more irritable and short-tempered?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you felt that your memory and/or intellect is impaired?                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been told that you stop breathing while asleep?                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have difficulty breathing through your nose?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any immediate family members been diagnosed or treated for sleep disorder?               |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any family members been diagnosed with heart disease, high blood pressure or diabetes?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? How many? _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | How often do you consume alcohol within 2-3 hours of bedtime?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | How often do you consume caffeine within 2-3 hours of bedtime?                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wake up at night? How many times? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any other therapy for breathing disorder? Wt. Loss / Surgery / Smoking Cessation |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an evaluation at a sleep center   |
|                          |                          | Sleep Center Name: _____  |
|                          |                          | Location: _____   |
|                          |                          | Sleep Study Date: _____   |

1. When did your symptoms first start?  
\_\_\_\_\_  
\_\_\_\_\_

2. Was there a specific incident, accident or injury that seemed to trigger your symptoms?

---

---

3. Do your present symptoms effect your relationships with family & friends? If so, how?

---

---

4. What are your expectations in seeking treatment at this time?

---

---

5. What do you see yourself doing after treatment that you are not able to do now?

---

---

Patient Weight: \_\_\_\_\_

Patient Neck Circumference: \_\_\_\_\_

Patient Height: \_\_\_\_\_

Patient Waist: \_\_\_\_\_

Normal time to go to bed: \_\_\_\_\_

Normal wake up time: \_\_\_\_\_

Number of hrs. of sleep: \_\_\_\_\_

Quality of sleep (Good/Fair/Poor): \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge.

Patient / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired.**

Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Write down the number corresponding to your choice in the right hand column. Total your score below.

| Situation   | Chance of Dozing |
|---|------------------|
| Sitting and reading   | •                |
| Watching TV   | •                |
| Sitting inactive in a public place (e.g., a theater or a meeting) | •                |
| As a passenger in a car for an hour without a break               | •                |
| Lying down to rest in the afternoon when circumstances permit     | •                |
| Sitting and talking to someone                                    | •                |
| Sitting quietly after a lunch without alcohol                     | •                |
| In a car, while stopped for a few minutes in traffic              | •                |

**What are the chief complaints for which you are seeking treatment ?**

Please **NUMBER** the complaints with #1 being the primary reason for seeking treatment.

- |  |  |
|--|--|
| <p>_____ Frequent heavy snoring</p> <p>_____ Snoring which effects the sleep of others</p> <p>_____ Significant daytime drowsiness</p> <p>_____ I have been told, "I stop breathing" when sleeping</p> <p>_____ Gasping when waking up</p> <p>_____ Nighttime choking spells</p> | <p>_____ Feeling unrefreshed in the morning</p> <p>_____ Morning Hoarseness</p> <p>_____ Morning Headaches</p> <p>_____ Swelling in ankles or feet</p> <p>_____ Nocturnal teeth grinding</p> |
|--|--|

I certify that the above information is correct to the best of my knowledge.

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IF YOU HAVE NOT WORN A CPAP DEVICE, SKIP THIS SECTION**

**CPAP HISTORY:**

YES NO Do you wear a CPAP device successfully during sleeping?  
How many hours per night do you wear your CPAP? \_\_\_\_\_

YES NO Have you tried other therapies for your sleeping disorder?  
Please list other therapies (Weight-loss attempts, smoking cessation, surgeries, etc.)  
\_\_\_\_\_

**If you are unable to wear a CPAP device, please check below reasons for your difficulty.**

- Mask Leaks
- Mask Uncomfortable/Device Uncomfortable
- Unable to sleep comfortably
- Noise disturbs my sleep and/or bed partner's sleep
- Restricts movement during sleep
- Does not seem to be effective
- Straps/headgear cause discomfort
- Pressure on the upper lip causes tooth related problems
- Latex Allergy
- Claustrophobia
- Other \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge.

Patient / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

**Sleep Study Date:** \_\_\_\_\_

The evaluation confirmed a diagnosis of \_\_\_\_\_

- Mild
- Moderate Obstructive sleep apnea
- Severe

The evaluation showed

|                 | during REM | Supine | Side  |
|-----------------|------------|--------|-------|
| an RDI of _____ | _____      | _____  | _____ |
| an AHI of _____ | _____      | _____  | _____ |

A nadir SpO2 of \_\_\_\_\_ T90 \_\_\_\_\_

Slow Wave Sleep  Decreased  None  
REM Sleep  Decreased  None

To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist. *Please initial* if you want us to send them a report from your visit.

*Initial* FAMILY PHYSICIAN

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* CHIROPRACTOR

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* ENT

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* ALLERGIST

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* PSYCHIATRIST

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* PULMONOLOGIST

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* DENTIST

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* PHYSICAL THERAPIST

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* CARDIOLOGIST

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* NEUROLOGIST

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* PSYCHOLOGIST

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

*Initial* OTHER

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

- I understand and agree to have the indicated professionals I have listed above be sent initial information and ongoing updates regarding my diagnoses and treatment.
- I do not wish to have my records sent at this time.

I certify that the above information is correct to the best of my knowledge.

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



12620 Clarksville Pike (Route 108)  
Clarksville, MD 21029  
(410) 531-5639  
(410) 531-6625 fax  
www.ParmarDMD.com

CONSENT AND RELEASES

Patient Name: \_\_\_\_\_

Initial

\_\_\_\_\_ I hereby authorize Dr. Rashmi Parmar and/or her staff to take X-rays, impressions, photographs, slides, and/or videos of my face, jaws and teeth. I understand that the X-rays, impressions, photographs, slides and/or videos can and will be used as a record of my care and treatment, and hereby authorize their use for educational purposes in future lectures and demonstrations by Dr. Parmar and/or her staff.

\_\_\_\_\_ I hereby give permission to have my testimonials and/or X-rays, impressions, photos, slides and videos utilized by Dr. Parmar and/or her staff for professional marketing to help other patients understand the benefits of the services rendered by this office. I further understand that I will receive no financial compensation for their use, at anytime, now or in the future, of my testimonials, photos, slides and/or videos by Dr. Parmar and her staff.

\_\_\_\_\_ I understand that responsibility for payment of dental services provided by this office for myself or my dependent(s) is solely mine, with full payment due and payable at the time of services rendered. In the event of default in any payment, I promise to pay the legal interest rate on such indebtedness until fully paid together with all collection cost(s) including but limited to, non sufficient funds fees, court costs and reasonable attorney's fees that may be required to effect full collection of this note and any balance due hereunder, whether or not formal litigation is instituted.

\_\_\_\_\_ I understand that all services are NOT rendered on the basis that the Insurance Company will pay all of Dr. Parmar's and/or her office fees. Most Insurance Companies may pay only a portion of the services provided. We will be happy to file the necessary forms to see that you receive full benefits of your coverage, however, we make no guarantee of any estimated coverage. We will file primary Insurance. Patients are responsible for filing any secondary insurance coverage they may have.

\_\_\_\_\_ I understand that I must provide a 48 hours advance notice for cancellations of any of my appointments in order to avoid the imposition of cancellation fees, which are determined by the length and type of services being rendered at that scheduled visit. Such cancellation fees are non-refundable and can range from \$50 to \$400.

\_\_\_\_\_ I understand that Dr. Parmar and/or her staff make every effort to see the patients on time, however, emergencies and/or other situations do arise that may sometimes lead to added wait time. I also understand that my appointment has some leeway built into it so that my procedure will be completed.

\_\_\_\_\_ I authorize Dr. Parmar and/or her staff 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 involves a certain risk. Furthermore, I authorize and consent that Dr. Parmar and/or her staff choose and employ such assistance as deemed fit to provide recommended treatment.

\_\_\_\_\_ In case of the need to transfer records, I understand that it will require five working days to duplicate the records. A reasonable record duplication and transfer fee charge will be collected prior to any record transfer.

I have read and understood this entire agreement before initializing and signing and have done it voluntarily without duress and of my own free will and choice.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



12620 Clarksville Pike (Route 108)  
Clarksville, MD 21029  
(410) 531-5639  
(410) 531-6625 fax  
www.ParmarDMD.com

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

|       |           |         |
|-------|-----------|---------|
| Date: | Initials: | Reason: |
|-------|-----------|---------|