DENTAL ATTRACTION CENTER
DR. SAEED ROUHANI

"We treat you beautifully"

Name _____Preferred Name: _____
Date of Birth: _____SS#: _____DL #/State: _____
Address: _____Apt. #:_____ City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ E-mail: _____
Marital Status: _____Reason for Dental Visit: _____ How did you hear about our office? _____
If you could change anything about your mouth, teeth or smile, what would it be? _____

Medical History

Are you under a physician care now? ○Yes ○No If yes, please explain: _____
Are you taking any medications or drugs? ○Yes ○No If yes, please list: _____
Are you allergic to any drugs or medication? ○Yes ○No If yes, please list: _____
In case of an emergency, whom may we contact? _____ Phone #: _____

Please check if any of the following apply to you:

AIDS/HIV Positive	○Yes ○No	Diabetes	○Yes ○No	High Blood Pressure	○Yes ○No	Renal Dialysis	○Yes ○No
Alzheimer's Disease	○Yes ○No	Drug Addiction	○Yes ○No	High Cholesterol	○Yes ○No	Rheumatic Fever	○Yes ○No
Allergies	○Yes ○No	Emphysema	○Yes ○No	Hives or Rash	○Yes ○No	Scarlet Fever	○Yes ○No
Anemia	○Yes ○No	Epilepsy or Seizures	○Yes ○No	Hypoglycemia	○Yes ○No	Shingles	○Yes ○No
Arthritis/Gout	○Yes ○No	Fainting/Dizziness	○Yes ○No	Irregular Heartbeat	○Yes ○No	Sickle Cell Disease	○Yes ○No
Artificial Heart Valve	○Yes ○No	Frequent Headaches	○Yes ○No	Kidney Problems	○Yes ○No	Sinus Trouble	○Yes ○No
Artificial Joints	○Yes ○No	Glaucoma	○Yes ○No	Latex Allergy	○Yes ○No	Spina Bifida	○Yes ○No
Asthma	○Yes ○No	Hay Fever	○Yes ○No	Leukemia	○Yes ○No	Stomach/intestinal	○Yes ○No
Blood Disease	○Yes ○No	Head Injuries	○Yes ○No	Liver Disease	○Yes ○No	Stroke	○Yes ○No
Blood Transfusion	○Yes ○No	Heart Attack/Failures	○Yes ○No	Low Blood Pressure	○Yes ○No	Swelling of Limbs	○Yes ○No
Breathing Problems	○Yes ○No	Heart Murmur	○Yes ○No	Lung Disease	○Yes ○No	Thyroid Disease	○Yes ○No
Cancer	○Yes ○No	Heart Pacemaker	○Yes ○No	Mitral Valve Prolapsed	○Yes ○No	Tonsillitis	○Yes ○No
Chemotherapy	○Yes ○No	Hemophilia	○Yes ○No	Nervous Disorder	○Yes ○No	Tuberculosis	○Yes ○No
Chest Pains	○Yes ○No	Hepatitis A	○Yes ○No	Osteoporosis	○Yes ○No	Tumors or Growths	○Yes ○No
Cold Sores	○Yes ○No	Hepatitis B or C	○Yes ○No	Psychiatric Care	○Yes ○No	Ulcers	○Yes ○No
Cortisone Medicine	○Yes ○No	Herpes	○Yes ○No	Radiation Treatments	○Yes ○No	Venereal Disease	○Yes ○No

Women

Are you Pregnant? ○Yes ○No Are you taking contraceptives? ○Yes ○No Are you Nursing? ○Yes ○No

Do you have a health condition/problem we have not covered: ○Yes ○No If yes, please list:_____
_____

Dental History

Do you experience any of the following?

○ Clicking or popping of the jaw
○ Difficulty in chewing on either side of the mouth
○ Headaches, neck aches or shoulder aches
○ Clenching/ Grinding
○ Pain in joint, ear, side of face
○ Difficulty in opening or closing the mouth
○ Sore muscles (neck, shoulder)

Date of last dental visit: _____ what services were rendered? _____ is there anything else you would like our doctor to know about you? (Fears, bad experience, good experience etc.) _____

Medical Insurance Information

Name of Insurance: _____
Name of Insured/Sub: _____
Insured Id: _____
Insured DOB: _____
Insurance Phone #: _____

Dental Insurance Information

Name of Insurance: _____
Name of Insured: _____
Insured Id: _____
Insured DOB: _____ _____
Insurance Phone #:_____

To the best of my knowledge, all the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Initial_____

Authorization

I hereby certify that I have read and understand the medical history information is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostics aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian: _____ Date: _____
Please Print Name: _____

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We are privileged you have chosen us as your dental care provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to treatment. If you have any questions, please feel free to ask.

FINANCIAL POLICY

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, all major credit cards and care credit.

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and copayments as accurately as possible. Please understand that all treatment plans given are only an **ESTIMATE** based on the information your insurance company provides. All deductibles and co-payments are due the day the treatment is rendered.

Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim.
REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL. Once a payment is received on your claim, we will send you a bill for any remaining balance on your account.

At our discretion, any unpaid balance after 90 days will be sent to collections at which the patient is responsible for any fees associated with the collection of the balance.

BROKEN APPOINTMENT POLICY

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion.

So that the dentist , our staff and our patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment (24 hours advance notification), will result in a $50.00 fee being charged. That charge which is in accordance with our dental office's broken appointment policy for all of our patients is to be paid within 30 days to prevent collection procedures. The patient/parent/legal guardian is responsible for the payment of the charge.

I have read and understand the above Financial Policy by signing below; I acknowledge responsibility and agree to the terms above.

Signature of Responsible Party: _____ *Date:* _____
Please Print Name: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Responsible Party: _____

Patient Name: _____

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 health care 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 health care operations, of the use and disclosures we may make of your health information, and other important matters about your protected health information, and or other important matters about your protected health information. A copy of our notice is available upon request. 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 at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation of this Consent, this 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 continue treating you if you revoke this consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this form and your Notice of Privacy Practices; I understand that, by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____ Date: _____
Relationship to Patient: _____