PATIENT INFORMATION

Name: ________________________________ Date of Birth: ____/____/____ Age: ________

Address: ____________________________________ City: ______________ State:____ Zip:_______

Marital Status: ____________ SSN: _____-_____-_____ Home Phone: _______________ Work Phone: _______________

Cell Phone: _________________ Employer: _________________________ Occupation: ___________________________

Email Address: ________________________________ How did you hear about our office? _________________________

May we confirm your appointment via email/ text? ☐ yes ☐ no

SPOUSE OR PARENT INFORMATION

Name: ____ Direct Phone Number: _____________________

Employer: ___________________________ Occupation: _________________________

DENTAL INSURANCE

Policy Holder: ____ SSN: _____-_____-_____

Date of Birth: ____/____/____ Insurance Company: _____________________ Phone Number: ___________________

CONSENT FOR TREATMENT

I certify that all information I have provided is accurate and complete and that I will assume responsibility for fees associated with all dental procedures, diagnostic aids, etc. I understand that this is my responsibility to inform your office of any changes to the information above.

Patient (Parent) Signature: _________________________________ Date: ______________________________

IN CASE OF EMERGENCY, CALL # ____

Name: ____

Relationship: _____________________________________

MEDICAL HISTORY

Patient Name: ____________________________________

Family Physician: ______________________________ Phone Number: ________________

Pharmacy: __________________________________ Phone Number: __________________

If you are taking any of the following, please circle which one(s): Zometa Fosamax Actonel Aredia

Do you take a blood thinner? YES or NO If yes, what? ____

Alcohol / Tobacco / Drugs: (Cigarette use, alcoholism, or drug dependence) YES or NO

Please list any *medications* you take: ____

Please list any *allergies* you have (penicillin, codeine, sulfa drugs, Latex): _________________________________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- Joints, organs, body parts replaced? If so, when / what? ______________________________
- Abnormal bleeding / blood disorder
- Arthritis
- Asthma
- Cancer __________ Date _________
  - Chemotheraphy Date __________
- Cholesterol
- Cold Sores
- Diabetes
- Epilepsy
- Fainting Spells
  - Last episode ______________
- Heart Disease
- Heart Attack Date ______________
- Heart Murmur
- AIDS, ARC, or HIV+ (Circle one)
- HIGH or LOW blood pressure (Circle one)
- Hepatitis Type ________________
- Kidney Problems
- Mitral Valve Prolapse
- PaceMaker
- Radiation Therapy Date _____________
- Rheumatic Fever
- Seizures Last Episode ______________
- Sinus Problems
- Sleep Apnea
- Stroke Date ___________
- Thyroid Problems
- Tuberculosis or Lung Disease

Is there any other disease, condition, or problem that we should know about? _________________________________

For female patients, are you taking birth control medication? YES or NO Kind: ______________________________

If you are pregnant, how many months? _______________ Breast Feeding: YES or NO

DENTAL HISTORY

When was your last dental visit? ____/____/____ What was done? ________________________________

Have you had any of the following? ☐ Orthodontics (braces) ☐ Gum Surgery/Deep Cleaning ☐ Oral Surgery

Are you aware of any grinding/clenching of your teeth? YES or NO

Do you suffer anxiety or gagging during dental procedures? YES or NO

Are you unhappy with the appearance of your teeth? YES or NO Why? _______________________

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for any errors that I may have made in the completion of this form.

Patient (Parent) Signature: ______________________________ **Date:** ___________________________

Office use only - _________ Scanned in Documents _________ Updated in Chart

SCHEDULING AND FINANCING POLICY

Welcome to our practice, and thank you for choosing us to serve your dental needs. We pledge to strive in every way to make your visits cordial, timely and comfortable.

+ Our staff values your time and will never knowingly make you wait excessively. You will notice that our reception area is rarely full, as all chair time appointments are reserved individually. We confirm with a phone call at least 48 hours in advance.
+ All appointments are specifically scheduled for you. If you cannot make your appointment, please inform us at least 24-48 hours in advance so that we can offer this appointment time to another patient.
+ Last minute non-emergency cancellations are unacceptable and will result in a **$25.00 charge for every 30 minutes of appointment time missed.** Therefore, two no-show or last minute cancelled appointments may result in a deposit for further appointments.
+ **We are a fee for service office. Thus, all balances, insurance deductibles and co-insurances are due at the time of service.** For your convenience, we offer payment by Visa, Mastercard, Discover, check, cash or Care Credit.
+ All returned checks have a **$25.00** return service charge.
+ Once your account has reached 90 days overdue, we will send a final letter. If this amount is still unpaid by the requeste date, all debts will be forwarded to IC Systems collection agency.
+ If you have insurance, we will try to get as accurate of an estimation as possible for your dental needs as a courtesy to you. *However, we as the dental provider have the relationship with you, not the insurance company.* **Please be aware that the information that is given to us by the insurance company is only estimation and not a guarantee of payment.**

REPAIR- REPLACEMENT POLICY

The following will be repaired, replaced or modified at the office's discretion at **NO CHARGE** for a period of **1 year** from the date inserted or delivered:

+ **CROWNS:** Recementing of crown or fracture of porcelain. Does not include replacement due to decay.
+ **BRIDGES:** Recementing of crown or fracture of porcelain. Does not include replacement due to decay.
+ **PARTIAL/DENTURES:** Loss of teeth, fracture of denture base or clasps breakage.
+ **VENEERS:** Fracture or chipping of veneer. Loss of or 'popping off' of veneer.
+ **FILLINGS:** Fracture or loss of the filling. Does not cover new decay detected after filling is placed.

By signing below, I have read and understood the Scheduling/Financing Policy and the Repair- Replacement Policy and I agree to meet and follow all obligations.

Patient (Parent) Signature: ________________________________ **Date:** ______________________________

NOTICE OF PRIVACY PRACTICES (*you may refuse to sign this)

I have reviewed / received a copy of *Kawveh Nofallah, D.M.D.'s* Notice of Privacy Practices.

Patient (Parent) Signature: ________________________________ **Date:** ______________________________

AUTHORIZATION TO RELEASE CONFIDENTIAL PATIENT INFORMATION

I request to authorize Dr. Nofallah or staff member to disclose and provide copies of any and all clinical treatment records and information

concerning my care to ____.

These records include, but are not limited to: personal information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models and other related materials. **The authorized person(s) listed above will be able to make and cancel all appointments.**

Patient Signature: ________________________________ **Date:** ______________________________

Office use only - _________ Scanned in Documents _________ Updated in Chart