



# SHUAYB DENTAL

Name \_\_\_\_\_ nickname \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Soc Sec # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home# \_\_\_\_\_

Birth date \_\_\_\_\_ Sex  M  F Cell # \_\_\_\_\_

Email \_\_\_\_\_ DL # \_\_\_\_\_

Minor  Single  Married  Widowed  Separated  Divorced

Employer/Occupation \_\_\_\_\_ Work # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home# \_\_\_\_\_ Work # \_\_\_\_\_

### ***Person responsible for account (if patient is a minor)***

Name \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Relation to patient \_\_\_\_\_ DL# \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_

### ***Insurance information***

Name of subscriber \_\_\_\_\_  
Last First Middle

Relation to patient \_\_\_\_\_ Birth date \_\_\_\_\_ Soc Sec # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

## Dental History

Reason for Today's visit \_\_\_\_\_

Interested in Whiter Brighter Smile? \_\_\_\_\_

If you could change your smile what would you change? \_\_\_\_\_

Date of last dental x-rays \_\_\_\_\_

Check if you have any of the following:

- |                                     |  |  |   |
|-------------------------------------|--|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding teeth        | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Clicking for popping jaw |
|                                     | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity   |   |

## Medical History

Have you had any serious illnesses or operations?  No  Yes Describe: \_\_\_\_\_

**Women:** Are you pregnant?  No  Yes      Nursing?  No  Yes      Taking Birth Control Pills?  No  Yes

Check if you have any of the following:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> <b>Artificial Joints</b> | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Hay fever           |
| <input type="checkbox"/> Kidney disease           | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Rheumatic/Scarlet fever  | <input type="checkbox"/> Thyroid disease     | <input type="checkbox"/> Blood transfusion          | <input type="checkbox"/> Herpes              |
| <input type="checkbox"/> Heart murmur             | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> AIDS/HIV positive          |  |
| <input type="checkbox"/> Heart pacemaker          | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Stroke                     |  |
| <input type="checkbox"/> Artificial heart valve   | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Chemotherapy/Radiation     |  |
| <input type="checkbox"/> Arthritis, Rheumatism    | <input type="checkbox"/> Psychiatric Care    | <input type="checkbox"/> Hemophilia                 | <input type="checkbox"/> COPD                |
| <input type="checkbox"/> <b>Latex Allergy</b>     | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Tobacco habit              | <input type="checkbox"/> Blood Thinners      |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Fainting or dizzy spells   |  |
| <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Epilepsy/seizures   | <input type="checkbox"/> Anemia/Sickle cell disease |  |

Any problem not listed? \_\_\_\_\_

**List all medication you are currently taking:**

**List drug allergies:**

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\* I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance.

\*I assign dental benefit payments to be paid directly to Dr. from my insurance company.

\* I give permission for my dentist and his/her clinical team to take any necessary diagnostic films, photos or study models to properly enable complete diagnosis and treatment.

## **Authorization & Release**

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to my medical status. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all my insurance submissions. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

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

## **Financial Policy**

**Welcome** to our dental practice! We are glad to have you as our patient, and look forward to the opportunity to meet your dental health needs.

**Our** mission is to deliver the finest, most cost effective treatment available today. Please **review** and **initial** the following so that we can achieve our mission together.

### **Payment**

Payment for services is due at the time services are rendered, unless specific arrangements are made in advance.

Payment may be made with cash, check, Visa, MasterCard, and Discover, and AMEX.

We offer payment plans thru Care Credit and Chase Health advance.

### **Insurance**

As a courtesy to those patients who are covered by insurance, we will bill your insurance for you and accept the assignment of benefits. However, we want to emphasize that our relationship is with you, not your insurance company. All charges are your responsibility from the date services are rendered, and your patient co-payment is due at the time of service.

We will estimate your co-payment to the best of our ability, but the estimate is simply a guideline until the final insurance payment is received. If there is a remaining balance following insurance payment, this balance must be paid within 30 days of being billed by this office.

We strongly advise you to become familiar with your specific insurance plan and your covered benefits, as every insurance plan is different, and some routine procedure may not be covered, or may be limited to certain frequency.

### **Billing Charges**

Account balances over 90 days may be subject to collection or legal action, unless prior arrangements have been made for the balance.

### **Returned Checks**

All returned checks are subject to a service charge.

### **Broken Appointments**

We try to schedule the Doctor's time around our patients, therefore we ask your consideration in calling if you are unable to keep your appointment. Although we do try to make courtesy call to remind you of your appointments, you are ultimately responsible to keep track of your appointments in case we are unable to reach you. **Failure to call and cancel an appointment 24 hours prior to your appointment will result in a \$40 fee. If you have 3 missed appointments this will result in a permanent dismissal from this office.**

Please feel free to ask any questions that remain unanswered either before or after treatment. We are here to help you!

## HIPPA consent form

**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 April 14, 2003, and will remain in effect until we replace it. **The Notice of privacy practices is available upon request and a copy of this notice is located in the waiting room.**

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

Parent signature if patient is  
minor \_\_\_\_\_