NEW PATIENT REGISTRATION

DFW ABSOLUTE DENTAL
MARIA SHAHDAD, DDS, GPR
CREATING BEAUTIFUL SMILES

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Birth Date: _____ Soc Sec: _____-_____-_____ Drivers Lic: _____

Address_____
Apt# City State Zip Code

Home Phone: (_____)-_____-_____ Cell Phone: (_____)-_____-_____ Work Phone: (_____)-_____-_____

Email Address: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated

Have you or another family member been a patient in our office before? Y / N If yes, Name _____

How did you hear about our office? _____

Reason for today's visit? _____

Responsible Party for Account: ◯ Same as Patient above

First Name: _____ Last Name: _____ Middle Initial: _____

Birth Date: _____ Soc Sec: _____-_____-_____ Drivers Lic: _____

Home Phone: (_____)-_____-_____Cell Phone: (_____)-_____-_____ Work Phone: (_____)-_____-_____

Emergency Contact Information:

Name/Relation: _____ Phone: (___)-____-_____

Insurance Information:

Insurance Company: _____ ◯ PPO ◯ DHMO ◯ Discount Plan

Name of Policy Holder: _____ Birth Date: _____

Policy ID: _____ Group ID: _____ Phone: (_____)-_____-_____

Employer: _____ Relationship to Policy Holder: ◯ Self ◯ Spouse ◯ Child ◯ Other

How would you rate your overall oral health? 1 2 3 4 5 6 7 8 9 10
Poor Excellent

How important is your oral health to you? 1 2 3 4 5 6 7 8 9 10
Not Important Very Important

Can we provide you with information about any other oral health concerns? (I.e.: dental implants, TMJ, Corrective Jaw Surgery)_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES ARISING FOR SERVICES DELIVERED AND I AUTHORIZE PAYMENT OF ANY MEDICAL/DENTAL INSURANCE BENEFITS TO DR. MARIA SHAHDAD. I AUTHORIZE THE RELEASE OF ANY INFORMATION PROVIDED IN MY MEDICAL/DENTAL RECORDS NECESSARY TO PROCESS MY CLAIM. I ATTEST THAT THE INFORMATION PROVIDED IN THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____

NEW PATIENT HEALTH HISTORY

DFW ABSOLUTE DENTAL
MARIA SHAHDAD, DDS, GPR
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PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Birth Date: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information. The Notice includes:

1. A statement that this practice is required by law to maintain the privacy of protected health information.
2. A statement that this practice is required to abide by the terms for the notice currently in effect.
3. Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, Payment, and Health Care Operations.
4. A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
5. A description of other uses and disclosures that are prohibited or materially limited by law.
6. A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
7. My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    1. The right to complain to this practice and to the Secretary of Health and Human Services if I believe my privacy rights has been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    2. The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    3. The right to receive confidential communications of protected health information.
    4. The right to inspect and copy protected health information.
    5. The right to amend protected health information.
    6. The right to receive an accounting of disclosures of protected health information.
    7. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

I agree to allow DFW Absolute Dental to release my personal information only for the purpose to remind me of my future appointments. I understand that DFW Absolute Dental prints my appointment time, date and reason on a reminder post card that is sent to my home or address, I have provided, one to two weeks prior to my appointment time.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Legal Guardian/Parent: _____ Date: _____

DENTAL TREATMENT CONSENT FORM

Patient Name: _____ Birth Date: _____

Health Information: I agree to disclose all previous illness and medical history. Undisclosed medical information and current medications, allergies or illness are risk factors.

Drugs, Latex, and Medicines: I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases heartbeat and depending on my health, may be dangerous to me.

Needle Stick: If someone is inadvertently stuck with a needle used on me, I consent to have blood drawn for analysis.

Fillings, Crowns, and Uni-anticipated Root Canals: Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done. Warranty is only valid if routine 6 month appointments are maintained.

Root Canals can fail: Root canals can fail and may require additional treatment or I may end up having the tooth extracted.

Porcelain Crowns, Veneers, Bonding and Cosmetic Fillings: Porcelain crowns, veneers, cosmetic bonding and composite fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding, or filling is placed, I understand the color cannot be changed.

I understand that I may need treatment beyond what was originally planned. If a crowned tooth becomes painful and will need a root canal, or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for the additional or specialty care.

Gum Treatment and Requesting "JUST A CLEANING": If I don't floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply get a cleaning (prophylaxis).

Extractions and Surgery: I understand that all extractions or surgeries carry risks. Some are minor, like a dry socket following an extraction. Some are life threatening, such as post-surgical infections or anaphylaxis.

Fee for Additional or Specialty Care: **Due to OSHA Regulations we are now charging a $15.00 fee.**

Limitations of Insurance Coverage: There are charges beyond what insurance will pay, such as bleaching or cosmetic work. As a service to our patients, this office will file insurance claims on their behalf as a courtesy. I understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what insurance does not cover and that the office only allows 90 days for the insurance to pay. The balance is ALWAYS my responsibility.

****24 Hour Cancellation*** – I agree to give a 24 hour notice for cancellation or pay the broken appointment fee of $50.00. I understand that leaving a message after the office is closed the day (or weekend) before is NOT sufficient notice.*

I DO NOT EXPECT GUARANTEES IN DENTAL CARE. I HAVE READ THE ABOVE AND CONSENT TO TREATMENT.

Signature: _____ Date: _____

Legal Guardian/Parent: _____ Date: _____