



# Welcome

*Thank you for choosing us as your dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet your entire dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us-we will be happy to help.*

## **Patient Information**

Name \_\_\_\_\_ Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

Sex Male  Female  Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_ Zip: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: Single  Married  Widowed  Divorced  Separated

Name Of Patient Spouse or Guardian \_\_\_\_\_

Do You Preferred To Received Calls At, Home  Work  Cell

Person To Contact In Case Of Emergency. \_\_\_\_\_ Phone Number \_\_\_\_\_

Whom May We Thank For Referring You? \_\_\_\_\_

Patient Employer \_\_\_\_\_ Work Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## **Responsible Party**

Name Of Person Responsible For This Account. \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_ Driver License Number \_\_\_\_\_

Date Of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Is This Person Currently A Patient In This Office? Yes  No

Signature Of Responsible Party \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Medical History**

Patient's Name \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Physician Name \_\_\_\_\_ Physician Phone \_\_\_\_\_

Are you currently taking any medications now? \_\_\_\_\_ If yes please list \_\_\_\_\_

Do you smoke or use any tobacco products? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ If yes numbers of weeks \_\_\_\_\_ Are you Nursing? \_\_\_\_\_

**Please check the Following Conditions That Applies:**

<b>Yes</b> <b><u>Conditions</u></b>	<b>Yes</b> <b><u>Conditions</u></b>	<b>Yes</b> <b><u>Conditions</u></b>
<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Psychiatric Problems
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Allergies	<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Seizures
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Shingles
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Sickle Cell
<input type="checkbox"/> Artificial Bones	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer-Chemotherapy	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Colitis	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> High Blood Pressure	<b><i>Allergies</i></b>
<input type="checkbox"/> Diabetes Difficulty Breathing	<input type="checkbox"/> HIV + AIDS	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Codeine
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Erythromycin
	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Jewelry
	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Latex
	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Metals
	<input type="checkbox"/> Pneumocystitis	<input type="checkbox"/> Penicillin
	<input type="checkbox"/> Prosthetic Joint Repl.	<input type="checkbox"/> Tetracycline
		Other: _____

I have received a copy of the Notice of Privacy Practices from M.Yaghi DDS, PA.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

# M. Yaghi, D.D.S.

*Thank you for choosing us as your dental care provider. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.*

*All patients must complete our information form and provide insurance facts before seeing the doctor.*

## **APPLICABLE PAYMENT IS DUE AT TIME OF SERVICE.**

### **WE ACCEPT CASH, CHECKS AND/OR CREDIT CARD.**

#### ***Regarding Insurance***

We may accept assignment from your insurance benefits. However, the balance is **your responsibility**.

If your insurance company has not paid your account in full within 45 days, you are responsible for full payment of your account and have 10 days to remit payment to this office.

Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.

All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are participating providers, refer to above paragraph. We do not participate in **PPO** or **HMO** plans.

#### ***Usual and Customary Rates***

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Your up front charges may include a 10% allowance for your insurance company's arbitrary adjustment of the fee schedule.

#### ***Adult Patients***

*Adult patients are responsible for payment at time of service.*

#### ***Minor Patients***

The adult accompanying a minor and the patients (or guardians of the minor) is responsible for applicable payment.

#### ***Missed Appointments***

*Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of **\$50.00** per office visit. Please help us serve you better by keeping scheduled appointments.*

**Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.**

**I have read the Financial Policy. I understand and agree to this Financial Policy:**

X \_\_\_\_\_

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

Signature of Patient or Responsible Party

X \_\_\_\_\_

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

Signature of Co-Responsible Party

*M. Yaghi, D.D.S., P.A.*

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*Acknowledgement of Receipt*

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Notice of Privacy Practices

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***Patient Name & Address:***

*I have received a copy of the Notice of Privacy Practices for the above named practice.*

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Signature

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Date

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For Office Use Only

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We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

An emergency existed & a signature was not possible at the time.

The individual refused to sign.

A copy was mailed with a request for a signature by return mail.

Unable to communicate with the patient for the following reason:

Other: \_\_\_\_\_

Prepared By:

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Signature:

Date: