New Patient Packet 1

Patient Information

Today's Date

First Name

Last Name

Birth Date

Home Phone

Cell Phone

Work Phone

Email Address

Address

City

State

Zip

Check Appropriate Circle:

Patient's or Parents Employer

Spouse or Parent's Name

Employer

Work Phone

How did you hear about us?

Person to Contact in Case of Emergency

Relationship to Patient

Phone

Email Address

Responsible Party

Name of person responsible for this Account

Relationship to Patient

Address

Home Phone

Employer

Work Phone

SS #

Birth Date

Is this Person Currently a Patient in our Office?

Dental Insurance

Primary Carrier

Name of Insured

Birth Date

SS #

Employer

Insurance Company

Member ID

Group #

Address of Insurance Co.

City

State

Zip

Insurance Company Phone #

Do You Have Additional Insurance?

- ○ Yes
- ○ No

If Yes, Please Complete the following

Secondary Carrier

Name of Insured

Birth Date

SS #

Employer

Insurance Company

Group #

Address of Insurance Co.

City | State | Zip | Insurance Company Phone #

Patient Dental History

Name of Previous Dentist and Location | Date of Last Exam

2. Are your teeth sensitive to hot or cold liquids/foods or sweets?

○ Y
○ N

7. Have you ever experienced any of the following: problems in your jaws?

	Y	N
a-Clicking	○	○
b - Pain (joint, ear, side of face)	○	○
c - Difficulty in opening or closing	○	○
d - Difficulty in chewing	○	○

8. Do you have frequent headaches?

○ Y
○ N

9. Do you clench or grind your teeth?

○ Y
○ N

11. Have you ever had any difficult extractions in the past?

○ Y
○ N

12. Have you ever had any prolonged bleeding following extractions?

○ Y
○ N

16.

	Y	N
Do you like your smile?	○	○
If you could whiten your teeth for a cost anyone could afford, would you do it?	○	○
Do you smoke or use chewing tobacco?	○	○

If so, how much/often? For how long?

If I could change my smile, I would:

	Y	N
Make my teeth whiter	○	○
Make my teeth straighter	○	○
Enhance the appearance of my smile	○	○
Replace metal fillings with tooth colored restorations	○	○
Repair chipped teeth	○	○
Replace missing teeth or close spaces	○	○
Replace old crowns that don't match	○	○

Physician | Office Phone | Date of last Exam

1. Are you under medical treatment now?

○ Y
○ N

2. Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years?

○ Y
○ N

If yes, please explain;

3. Are you taking any medication(s) including non-prescription medicine?

○ Y
○ N

If yes, what medication(s) are you taking?

4. Do you use controlled substances?

○ Y
○ N

5. Have you ever taken Phen Phen or Redux?

○ Y
○ N

6. Are you allergic to or had any reaction to the following?

	Y	N
a-Local Anesthetics (e.g. novo caine)	○	○
b-Penicillin or any other Antibi otics	○	○
c-Sulfa Drugs	○	○
d-Barbiturates	○	○
e-Sedatives	○	○
f-Iodine	○	○
g-Aspirin	○	○
h-Any Metals (e.g. nickel, mer cury, etc.)	○	○
I-Latex Rubber	○	○
J-Other (please list)	○	○

7. Women Only

	Y	N
a-Are you pregnant or think yo u may be pregnant?	○	○
b-Are you Nursing?	○	○
c-Are you taking oral contrace ptives?	○	○

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	○	○	Deaf/Hard of hearing	○	○	Mitral Valv e Prolapse	○	○
Alzheime r's Diseas e	○	○	Emphyse ma	○	○	Osteoporo sis/Osteo penia	○	○
Anaphylaxi s	○	○	Epilepsy/S eizures	○	○	Parathyroi d Disease	○	○
Anemia	○	○	Excessive Bleeding	○	○	Psychiatri c Care	○	○
Angina	○	○	Excessive Thirst	○	○	Radiation Treatment s	○	○
Arthritis/G out	○	○	Fainting Sp ells	○	○	Recent We ight Loss	○	○
Artificial H eart Valve	○	○	Frequent H eadaches	○	○	Renal Dialy sis	○	○
Artificial J oint	○	○	Glaucoma	○	○			

If Other, please specify:

Asthma	○	○	Heart Attack	○	○	Sexually Transmitted Disease	○	○
Blood Disease	○	○	Heart Murmur	○	○	Shingles	○	○
Breathing Problems	○	○	Heart Pacemaker	○	○	Sickle Cell Disease	○	○
Bruise Easily	○	○	Hepatitis A, B, or C	○	○	Sinus Troubles	○	○
Cancer	○	○	Herpes	○	○	Stomach Pain/Ulcer	○	○
Chemotherapy	○	○	High Blood Pressure	○	○	Swelling of Limbs	○	○
Chron's/Ulcerative Colitis/IBS	○	○	Low Blood Pressure	○	○	Thyroid Disease	○	○
Cold Sores/Fever Blisters	○	○	Hypoglycemia	○	○	Tonsillitis	○	○
Congenital Heart Disorder	○	○	Irregular Heartbeat	○	○	Tuberculosis	○	○
Convulsions	○	○	Kidney Problems	○	○	Tumors/Growths/Ulcers	○	○
Cortisone Medicine	○	○	Leukemia	○	○	Other	○	○
Diabetes	○	○	Liver Disease	○	○			

The undersigned hereby confirms the above information is true and authorizes Doctor to take X-rays, study models. photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated In connection with (Patient name) and further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Patient/Parent Signature

Sign

Date

_____

Medical History Supplement

Are you now or have you ever been prescribed Bisphosphonates medications (for eg. Actonel, Boniva, Prolia etc.)?

○ Yes

○ No

If yes, how long have you taken this medication & for what medical condition?

Have you had tooth extractions, root canals, cleanings or restorations (fillings) since you have been taking this medication?

○ Yes

○ No

Any problems with these procedure?

Signed

Sign

Name:

_____

Date

_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Last Name

_____

First Name

_____

Middle Initial

_____

Maiden or Other Name

_____

Date of Birth:

_____

Phone:

_____

Address:

_____

City:

_____

State:

_____

Zip:

_____

☐ I authorize

Dr. Maryam Roosta to disclose my X-Rays related to the date above

Please release these records to:

Name:	Phone:	Fax:	Email:

You have the right to receive a copy of this authorization. This authorization expires one year from date of signing or on.

Patient or Legal Representative Signature	Date	Print Patient or Legal Representative Name/Relationship
Sign		Sign

Your Rights Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully. The privacy of your health information is important to us.

Your Rights When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Get an electronic or paper copy of your medical record • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. Ask us to correct your medical record • You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days. Request confidential communications • You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say “yes” to all reasonable requests. Ask us to limit what we use or share • You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say “no” if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. • We will say “yes” unless a law requires us to share that information. Get a list of those with whom we’ve shared information • You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. Get a copy of this privacy notice • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Choose someone to act for you • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: • Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission: • Marketing purposes • Sale of your information • Most sharing of psychotherapy notes In the case of fundraising: • We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition. Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services. Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services. How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. Help with public health and safety issues • We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone’s health or safety Comply with the law • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law. Respond to organ and tissue donation requests • We can share health information about you with organ procurement organizations. Work with a medical examiner or funeral director • We can share health information with a coroner, medical examiner, or funeral director when an individual dies. Address workers’ compensation, law enforcement, and other government requests • We can use or share health information about you: • For workers’ compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services Respond to lawsuits and legal actions • We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information. • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. • We must follow the duties and privacy practices described in this notice and give you a copy of it. • We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. Effective Date of Notice - 10/26/2020 Excel Dental Care,

Patient or Legal Guardian Signature

Sign

Printed Name

OFFICE POLICY AGREEMENT

Welcome to our Practice; In our continuing efforts to provide comprehensive dental care to you, our valued patients, we ask that you become acquainted with our office policy. If at any time you have any questions, please feel free to ask so that we may better serve you. All recommended treatments are in the best interests of our patients. We will not allow insurance companies to dictate treatment so therefore we will inform you of the fees before we perform all procedures. We will assist you in your payment options to help you receive the treatment that is necessary for your needs. Also, we have a website where you will be able to conveniently access your account and information.

DENTAL INSURANCE:

Our office will file most claims to your insurance carrier on your behalf and provide all necessary information to process your claim. Our office is neither an agent nor an employee of the insurance company. We accept the assignment of estimated insurance benefits as a courtesy to our patients, provided that you submit a completed original insurance claim form or card. The relationship we have is with you, our patient. If for any reason, your insurance does not pay for services rendered by Dr. Maryam Roosta, you, the patient, are solely responsible for your balance. All estimated co-payments and deductibles are due when service is rendered.

PREFERRED METHOD OF PAYMENT:

Our office accepts payment by cash, checks (with proper ID), and all major credit cards. For patients who require financial assistance, we offer different payment plans through a third party (upon approval) which allows you to start a treatment today and spread payments over a comfortable period of time. There will be a $50.00 returned check fee applied to your account in the event that the bank denies your check. Payment will be expected within 48 hours from the bank, in cash or money order.

GENERAL APPOINTMENTS:

We reserve appointment time, especially for you and your specific dental needs. We ask that you kindly give us TWO FULL BUSINESS DAYS (48 hour) notice if you are unable to keep you appointments. The fee for cancelling appointments with less than 48 hours is $58.00. When a family is going to be seen on the same day, we require ONE WEEK notice if two or more members need to cancel their appointments. When more than one appointment is cancelled with less than one week notice, we will charge each member of the family who cancels the appointment. When you are scheduled for an appointment, we have set aside time to address your questions and concerns. Therefore, it is essential that all patients arrive at their scheduled tie. Should you arrive 15 minutes late for your scheduled appointment time, your appointment will or may need to be rescheduled.

SPECIALTY APPOINTMENTS:

Periodontal procedures & Crowns/Bridges: These appointments require a span of time set aside, especially for you. We require three business days' worth of notice if you are unable to keep your appointment. The fee is $65.00 for a broken appointment.

Oral, Implant, and Periodontal Surgeries And Friday Appointment:

These appointments require large spans of time set-aside especially for you. We require four business days' worth of notice if you are unable to keep your appointment. The fee is $100.00 for a broken appointment. Appointment delays unfortunately do occur occasionally, they happen due to a dental emergency that one of our patients is having or when a patient needs more time with a doctor or dental hygienist. We ask for your understanding if this should occur.

DUPLICATION FEE:

Because there is some cost incurred for duplicating records, we require a fee of $35.00 and at least 5 days' worth of notice to process the request.

AGREEMENT TO PAY:

There will be a finance charge of 1.5% per month ($0.50 minimum) on all balance's overdue by 60 days with an additional $58.00 late fee per month. In the event that if there is a default of payment on any amount due, and your account is placed in the hands of an attorney or collections agency, you will be charged an additional amount of 33% to the processing fee as well as any collection agency/attorney fees. You the undersigned, have read and agree to the terms listed above as acknowledge receipt of a copy of this form.

Name:

Relationship to Patient:

Patient/Legal Guardian Signature:

Sign

Date: