PATIENT INFORMATION:

Patient's Name: _____
(First) (Middle Initial) (Last) (Preferred)

Social Security #: _____-_____-_____ Date of Birth: _____-_____-_____ Sex: M F

Single Married Child Other_____ Who can we thank for referring you? _____

Occupation: _____ Email: _____

Address: _____
(Address) (Apt #) (City) (State) (Zip)

Cell Ph# (_____) _____-_____ Work Ph# (_____) _____-_____

Emergency Contact Name/Relationship: _____ /_____

Emergency Contact Phone #: (_____) _____-_____

If not the patient, who is financially responsible for this account? _____

Relationship to Patient: _____ Social Security #: _____-_____-_____

Date of Birth: _____-_____-_____ DL#/State: _____ /_____

Address: _____
(Address) *(Apt #)* *(City)* *(State)* *(Zip)*

Cell Ph# (_____) _____-_____ Work Ph# (_____) _____-_____

INSURANCE---INSURED/SUBSCRIBER/POLICY HOLDER INFORMATION

Name: _____ Date of Birth: _____ /_____/_____

ID or Social Security #:_____ Relationship to Patient:_____

Employer:_____ Group #:_____

Insurance Name:_____ Insurance # (_____) _____-_____

Reason for today's visit: _____

Former Dentist Name and phone #_____

MEDICAL HISTORY

YES NO Are you being treated by a physician now?

Physician's Name: _____ Ph#: _____

YES NO Have you ever had any major surgery or illness? If yes, pls Identify: _____

YES NO Allergic to any medication? If yes, pls Identify: _____

YES NO Are you currently taking any medicaions (prescription &/or over the counter?) If yes, pls Identify:

_____

_____

Pharmacy Name_____ Phone # (_____) _____- _____

Please CIRCLE if you have or have had any of the followings?

AIDS/HIV	Circulatory Problems	Jaundice	Rheumatic Fever
Anemia	Cortisone Treatments	Jaw Pain	Shortness of Breath
Arthritis, Rheumatism	Cough, persistent or bloody	Joint Replacement	Sinus Trouble
Artificial Heart Valves	Diabetes	Liver/Kidney Disease	Stroke
Artificial Joints	Emphysema	Low Blood Pressure	Swelling of Feet or Ankles
Asthma	Epilepsy	Mitral Valve Prolapsed	Swollen Neck Glands
Back Problems	Fainting or dizziness	Nervous Problems	Smoking/Vaping
Bleeding Abnormally,	Glaucoma	Nursing	Thyroid Problems
Birth Control Pills	Headaches	Pacemaker	Tonsillitis
Blood Disease	Heart Issues: Mumur/Lesion/Problems	Pregnant (currently) Due Date	Tuberculosis
Cancer	Hepatitis Type _____	Psychiatric Care	Tumor or growth
Chemical Dependency	Herpes	Respiratory Disease	Ulcer
Chemotherapy or Radiation treatments	High Blood Pressure	Taken or Taking Phen-Fen or Redux	Venereal Disease

Taken or taking Fosamax, Boniva, Actonel or medications containing Bisphosphonates

YES NO **Are there any other medical problems that we should be aware of?** If yes, please explain:

_____

_____

CONSENTS

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any change in my health or medication for me and/or my dependent(s).

If you have insurance* I, the undersigned certify that I (or my dependent) have insurance coverage. I herby authroize payment directly to Ayas Family Dentistry, P.C.(DBA: Art of Dentistry) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I want to communicate via e-mail, fax or texting with Art of Dentistry on matters related to my health and /or my medical treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. And that any information Art of Dentistry sends is also unsecure. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail, fax or texting. I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail, fax or texting. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

Patient Signature: _____ Date: _____

Parent/Responsible Party Signature: _____ Date: _____

WELCOME TO OUR PRACTICE

Thank you for choosing our office as your dental care provider. As always, our primary goal is to provide the finest dental care available to all our patients. In order for our relationship to be cordial and satisfactory, we would like to inform you of our office policies.

FINANCIAL POLICIES:

Payment: Payment is due in full at the time of service unless prior arrangement as been made and approved in advance by our staff. We accept cash, bank card, Visa/MC, Discover, Care Credit and personal checks with valid I.D or Driver's License.

Missed and/or Late Cancelled Appointments: To better control the cost of dental care, guidelines have been established regarding missed and late cancelled appointments. Failure to give sufficient notice of at least 24 hrs prior (must be cancelled during working hours) will result in a missed or late cancellation charge of at least $45.00.

Minors: A parent or guardian must be present at the time of appointment, unless prior notice, consents and financials have been taken care of prior to the appointment. We request that parents/guardian to stay in the waiting room unless requested by the Dentist and or staff.

Insurance Assignment: While the patient is responsible for the total cost of treatment, as a courtesy we will file insurance on the patient's behalf (in most cases.) At the time of service, we estimate the insurance payment and collect the patient portion not expected to cover by insurance. Because we are a third party to your insurance company we can not guarantee what your insurance will or will not pay regardless of any quotes and/or pre estimations. Payments from dental insurance companies are accepted; however, the patient is responsible for any remaining balance after 45 days, regardless of the status of insurance claims.

RESPONSIBILITY AND CONSENT STATEMENTS:

I understand and acknowledge that I am financially responsible for the services provided for myself or a minor regardless of insurance coverage or payment.

In the event that my account becomes delinquent, I agree to pay all cost of collections, if necessary, including, but is not limited to: reasonable attorney's fees, inquired to satisfy my financial obligations.

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working that were not discovered during examination. For example, a root canal followed by restorative procedures.

For diagnostic purposes or dental treatment, I give my consent to any advisable and necessary dental procedures, medication or anesthetics to be administered by the attending dentist or by the supervised staff.

Patient Signature: _____ Date: _____

Parent/Responsible Party Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you the oportunity to receive a copy of our Notice of privay practices, which states how we may use and or disclose your health information. Please sign the form to acknowledge receipt of the Notice. You may refuse to sign this ackowledgement , if you wish.

I ackowldge that I have received a copy of this office's Notice of Privacy Practices. I also give permission to Art of Dentistry the authoriation to use and or disclose my protected health information to:

_____ _____

Name Relationship

_____ _____

Name Relationship

Patient Signature: _____ Date: _____

Parent/Responsible Party Signature: _____ Date: _____