PATIENT REGISTRATION

Patient Information

Date _____

Patient's Name _____ Preferred Name _____
Last First Middle

Address _____ Birth Date _____

City _____ State _____ Zip Code _____ Social Security #_____

Home Phone # _____ Cell # _____ Work # _____

E-Mail Address _____

Gender: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Who may we thank for referring you to our office? _____

Responsible Party Information (if someone other than patient)

Name _____
Last First Middle

Address _____ Birth-date _____

City, State, Zip _____ Social Security # _____

Home Phone # _____ Cell # _____ Work # _____

Relationship to Patient _____

We ask that you please notify us at least 48 hours in advance if needing to change or cancel any appointments – or a $50.00 charge will be assessed to your account.

Insurance Information

Name of Primary Insured _____ Relationship to Patient □Self □Spouse □Child □Other

Insured SS# or Alternate ID#_____ Insured Birth Date _____

Name of Insurance Co. _____ Employer _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Phone # _____ Phone # _____

Name of Secondary Insured _____ Relationship to Patient □Self □Spouse □Child □Other

Insured Social Security _____ Insured Birth Date _____

Name of Insurance Co. _____ Employer _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Phone # _____ Phone # _____

HEALTH HISTORY QUESTIONNAIRE

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

NAME (Last, First, MI.) _____ Birthdate _____

PERSONAL HEALTH HISTORY

Do you smoke or use Tobacco in any other form? Yes ☐ No ☐

Do you drink excessively Yes ☐ No ☐

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? Yes ☐ No ☐

Have you ever taken any dietary supplements such as Fen-Phen/Redux? Yes ☐ No ☐

ARE YOU **ALLERGIC TO OR HAVE REACTED ADVERSELY** TO ANY OF THE FOLLOWING MEDICATIONS? (CIRCLE) YES ☐ NO ☐

Aspirin Local Anesthetic Erythromycin
Penicillin Codeine Latex

Are you aware of being allergic to any other medications or substances? if yes, please list:_____ YES ☐ NO ☐

For Women:

	YES	NO
Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Are you using any type of birth control?	☐	☐

DENTAL HISTORY

	YES	NO
HOW LONG SINCE you have seen a dentist _____		
Last COMPLETE Dental Exam, Date _____		
Are you having PROBLEMS now?	☐	☐
WHAT? _____		
Are you currently in PAIN?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Do your gums BLEED, SORE, SWOLLEN or TENDER or IRRITATED	☐	☐
Are your teeth SENSITIVE To hot, cold, sweets, pressure? (circle)	☐	☐
Are your teeth loose?	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

MEDICAL HISTORY

	YES	NO
Do you have CURRENT HEALTH PROBLEMS?	☐	☐
Are you under PHYSICIAN'S CARE now?	☐	☐
For WHAT? _____		
Have you had surgery?	☐	☐
If so, Please Specify _____		
Do you have numbness or pain in the FACE/NECK/MOUTH	☐	☐
Do you have sore or lesion on lips or mouth for more than 2 wks	☐	☐
Do you have chronic horseness	☐	☐
Do you have lump or thickening in the cheek	☐	☐
Do you snore or have you been told you snore?	☐	☐
Is there a history of heart disease in your immediate fami	☐	☐
Do you have a family history of diabetes?	☐	☐

Medications Taken:_____

_____

_____

MEDICAL HISTORY

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Hepatitis	☐	☐
Anaphylaxis	☐	☐	High Blood Pressure	☐	☐
Anemia	☐	☐	High Cholesterol	☐	☐
Arthritis (Rheumatism)	☐	☐	Jaw pain	☐	☐
Artificial heart valves	☐	☐	Kidney disease or malfunction	☐	☐
Artificial joints	☐	☐	Liver Disease	☐	☐
Asthma	☐	☐	Mitral valve prolapse	☐	☐
Atopic (allergy prone)	☐	☐	Nervous problems	☐	☐
Back Problems	☐	☐	Pacemaker/heart surgery	☐	☐
Blood Disease	☐	☐	Psychiatric care	☐	☐
Cancer	☐	☐	Rapidweight gain/loss	☐	☐
Chemical dependency	☐	☐	Radiation Treatment	☐	☐
Chemotheraphy	☐	☐	Respiratory disease	☐	☐
Circulatory problems	☐	☐	Rheumatic/scarlet fever	☐	☐
Cortisone treatments	☐	☐	Shingles	☐	☐
Cough (persistent)	☐	☐	Shortness of breath	☐	☐
Cough up blood	☐	☐	Skin rash	☐	☐
Diabetes	☐	☐	Sleep Apnea	☐	☐
Epilepsy	☐	☐	Spina Bifida	☐	☐
Fainting	☐	☐	Stroke	☐	☐
Food Allergies	☐	☐	Surgical Implant	☐	☐
Glaucoma	☐	☐	Swelling of feet/ankles	☐	☐
Heart Murmur	☐	☐	Thyroid disease/malfunction	☐	☐
Heart problems (pls describe)	☐	☐	Tonsillitis	☐	☐
_____			Tubercolosis	☐	☐
Hemophilia (abnormal bleeding	☐	☐	Ulcer Colitis	☐	☐
Herpes	☐	☐	Venereal disease	☐	☐

Is there any other Medical or dental info that you feel I should know about

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibilty to inform the office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature (patient or paprent/guardian) _____ Date _____

Doctor's Signature _____ Date _____

Additional Questions

1. Are you happy with the appearance of your teeth? Yes ___ No ___

2. How do you rate the health of your teeth and gums? A. Good B. Fair C. Poor

3. Would you like to have whiter teeth? Yes ___ No ___

4. Are you interested to know more about **Invisalign,** the invisible braces to straighten teeth? Yes ___ No ___

5. If any of the following conditions apply to you, you may be a candidate for oral sedation (**Sleep Dentistry):**
   - **a.** high fear of dentistry
   - **b.** traumatic past dental experiences
   - **c.** difficulty getting numb/extremely sensitive teeth
   - **d.** limited time to complete extensive dental treatment

   Sleep Dentistry is a safe, simple and effective oral conscious sedation technique that may be used in conjunction with nitrous oxide gas (it is NOT general anesthesia and there are no IV tubes or needles involved). You will be given two or three small pills prior to your appointment and you'll be sedated just enough to be unaware of the treatment. You will be very relaxed and comfortable and will wake up within a few hours with little or no memory of your appointment. One of our team members will be with you during your entire visit and your vital signs will be constantly monitored. If you are in relative good general health there are only two requirements for sleep dentistry:
   1. No food or drink (except water) for six hours prior to treatment time.
   2. You will need a responsible adult to accompany (drive) you to and from the office.

   If you are interested in sleep dentistry or have further questions, please check here: Yes ___

6. **One final note**: (Regarding Adult patients only). Due to our inability to predetermine what type of cleaning a patient will need, a cleaning may not be done with the initial exam if for example; a deep cleaning is required instead of a routine one.

Signature _____ Date _____,

Dentistry at Dove Valley
(480)595-5688

Dentistry at Dove Valley
Dr. Kamran Ata-Abadi, DDS
Dr. Bahar Ata-Abadi, DDS

4705 E Carefree Hwy, Suite 126
Cave Creek, AZ 85331
(480) 595-5688
fax (480) 595-9233
dentistryatdovevalley@yahoo.com

Financial Policy

Welcome to our practice!

We know that providing complete comprehensive dental services includes discussing all treatment and financial information. Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

In order to better serve you, we want you to be aware of our office policies:

1. **Payment is due at the time services are rendered**, unless other arrangements have been made. For your convenience we accept cash, checks/money orders, and major credit cards. CareCredit financing may also be available to you.

2. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. Any deductible or estimated co-pay amount will be due at the time of treatment; in addition, you will be responsible for any amount your plan does not pay.

3. Appointments are reserved exclusively for you. **We reserve the right to charge and collect $20.00 for any broken appointments**. Broken appointments are considered those that are missed (no-show) and cancelled with less than 24-hour advance notice.

4. For the treatment of minors (under the age of 18), written consent from a parent or legal guardian is required for treatment.

Thank you again for choosing our office as your dental health provider.

I HAVE READ AND UNDERSTAND THIS POLICY AND AGREE TO ITS TERMS.

_____ _____

Patient or Guardian Signature *Date*

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Cave Creek, AZ 85331
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Insurance Policy

Due to the frequent changes in insurance plans and policies, we want to avoid as much misinformation as possible. Insurance benefits are determined by your employer, not your dentist; your insurance coverage and benefits are your responsibility. ***Insurance is not a guarantee of payment, and it often does not cover all the costs involved in treatment.***

You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment. Any deductible or estimated co-payment amount will be due **at the time of treatment**. In addition, you will be responsible for any amount your insurance plan does not pay, due (but not limited) to:

A. Cost of treatment goes over your insurance company's yearly maximum benefit.
B. Your insurance company denies treatment.
C. You are not eligible for insurance.
D. Your insurance benefits are less than what was estimated.
E. You prevent or delay payment by not complying with requests for insurance forms and signatures.
F. You do not complete treatment, and it results in non-payment by your insurance company.
G. Lab costs are incurred due to your failure to appear at your appointments.

We make every effort to ensure fees and co-pays are as accurate as possible at the time of your appointment; however, due to the volume and constant changes in insurance plans, we cannot assume responsibility for any discrepancies that may arise.

I HAVE READ AND UNDERSTAND THIS POLICY AND AGREE TO ITS TERMS.

_____ _____

Patient or Guardian Signature *Date*

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received and read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that the organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Private Practices.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment and payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____