Name_____Birthdate_____ SS#_____
Address_____ City_____
State_____Zip_____ Home Phone_____ Cell Phone_____
Employer_____ Occupation_____Work Phone_____
Email_____ Referred by_____
Spouse's name_____Birthdate_____SS#_____
Employer_____ Work Phone_____
Insured's Name_____ Insurance Company_____

MEDICAL HISTORY

Physician's Name_____ Date of last physical_____
Are you currently under the care of a physician? Y N Do you smoke cigarettes? Y N
Have you had any recent illness or surgery? Y N Do you chew tobacco? Y N
Are you pregnant? Y N Due date_____

Please check if you have (or had) any of the following:

○ AIDS/HIV
○Arthritis/Rheumatism ○Excessive bleeding ○Heart Disease
○Artificial Valves/ heart murmur/MVP (*PRE-MED Y N) ○Hepatitis (type:_____)
○Artifical Joints (DATE:_____) (*PRE-MED Y N)
○Asthma
○Chemotherapy ○Cancer/Tumors(please specify)_____date_____)
○Diabetes
○Epilepsy or seizures ○High/low blood pressure ○Pacemaker
○Liver disease ○Kidney disease ○Rheumatic fever
○Stroke ○Radiation treatment ○Hyper thyroid
○Other(specify_____) ○Tuberculosis ○Hypo thyroid

MEDICATION LIST (Please list ALL medications you are currently taking (or attatch a list)

_____

Have you or do you currently take any of the following medications?

Fosamax,Fosamax plus, Zometa,Didronel, Reclast,Boniva,Actonel,Aclasta,Acredia,Atelvia, Skelid, or any other medication containing Bisphosphonates (used to treat cancer ,osteoporosis or pagets disease (bone vitamins) Y N (please specify_____)

Allergies (please circle all that apply)

Latex Metal Sulfa Codeine Local Anesthetics Aspirin Penicillin Other Antibiotics

Dental History

Do you have any present dental complaints?_____
Last Dental visit_____ Last full set of X-Rays_____Last Cleaning_____
Have you ever had braces Y N Are you aware of any grinding or clenching of your teeth? Y N
Do you have any trouble getting numb after anesthetic is given? Y N

The information provided is true to the best of my knowledge. My questions about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any of his/her staff responsible for any error or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient/ Guardian Date

Financial Policy & HIPAA

If You Do Not Have Insurance: Full payment is due at the time treatment is rendered, unless other arrangements have been made in advance and approved by our office in writing. We are happy to accept Visa, MasterCard, American Express, Discover and can offer up to 6-month financing through CareCredit.

If We Accept Your Insurance Plan: As a courtesy to our insurance patients, we will submit covered services directly to your insurance carrier. In addition, we will **estimate** your portion of the fees, which will be due at the time of service. In event that your insurance company denies or underpays a claim, you will be responsible for the remaining balance of the account. Your payment must be received in our office no later than the due date indicated on your invoice.

Cancelled/Failed Appointments: Our mission is to provide the service you desire in a timely and professional manner. To achieve this, we offer flexible appointment scheduling. If you are unable to keep your scheduled appointment, we request that you extend a courtesy of a 24-hour cancellation notice. *Missed, cancelled or rescheduled appointments without proper notice may be subject to a cancellation fee at the rate of $50 per scheduled hour.*

Collections & Court Costs: If your account is not paid in full on the day of service (or by the due date on your invoice in case of insurance denial or underpayment), and you have not made prior financial arrangements with our office, your account may be turned over to our collections department without further notice. Accounts over 30 days past due are subject to a finance charge. The finance charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.00). In case of default of payment, accounts will be transferred to our collections department. Accounts turned over to collections are subject to collections costs of a minimum of 40% or $40 collection fee, whichever is greater, as well as court costs and attorney fees, for which you will be responsible. Please contact us immediately if you have questions about your invoice you have received from our office.

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY: I have read and agree to the terms of the Financial Policy. I understand that I am responsible to pay for services rendered, including reasonable attorney fees and costs of collection in the event of default. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance benefits.

▶ _____ _____ _____

Signature **Printed Name** **Date**

HIPAA ACKNOWLEDGMENT: the undersigned has reviewed the **Notice of Privacy Practices** and agrees to the terms set forth in the **HIPAA Information & Consents Form**. This consent shall remain in force from this time forward. The undersigned further agrees the Sharon Fahmy, DDS may make changes as necessary, with or without notice, to reflect updates and changes enforced by HIPAA regulatory agencies.

▶ _____ _____

Signature **Date**