Patient Information Form

Patient Name: _____ _____

Last First M.I. Preferred Name

Home Phone #:_____ Cell:_____ Work:_____

E-mail:_____ Social Security #: _____Birth Date: _____

Address: _____

Street City State Zip Code

Marital Status: _____Single ____Married _____ Child

Referred by: _____

Emergency Contact (Name, Phone number & Relation):

_____

Primary Insurance Information

Name of Subscriber: _____

Last First M.I.

Subscriber Birth Date: _____ID #: _____ Group #: _____

Social Security #:_____

Insurance Plan Name and Address:

_____

Insurance Company Phone Number:

_____

WOMAN ONLY: Are you pregnant?

- ☐ Yes
- ☐ No

If yes, when is the due date?

_____

Please indicate if you have experienced any of the following:

☐ Allergies	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Blood Disease
☐ Cancer	☐ Codeine Allergy	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting	☐ Glaucoma	☐ Growths
☐ Hay Fever	☐ Head Injuries	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ HIV	☐ Jaundice	☐ Kidney Disease
☐ Latex Allergy	☐ Liver Disease	☐ Mental Disorders
☐ Nervous Disorders	☐ Other	☐ Pacemaker
☐ Penicillin Allergy	☐ Pregnancy	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Sleep Apnea	☐ Stomach Problems
☐ Stroke	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Venereal Disease	

- ☐ Pre-Med ...If yes, with? _____

Do you have any other health issues or allergies?

List any medications you are currently taking.

Prior Dentist's name, address, & phone number:

_____

Please mark any of the following to indicate **Yes** in response to the question:

___ Do your gums bleed when you brush or floss?

___ Do your teeth experience sensitivity to cold or hot temperatures?

___ Are any of your teeth currently causing you pain?

___ Are any of your teeth loose, or are you concerned about any teeth loosening?

___ Do you currently have any dental implants, dentures or partials?

___ Do you grind your teeth (either consciously or during sleep)?

*Please make your doctor and hygienist aware if you have sleep apnea.

If you could change anything about your teeth or smile what would it be?

_____

☐ To the best, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Financial Policy

It is our long standing financial policy that your portion is due at the time services are rendered.

It is our pleasure to estimate your patient portion however it is never a guarantee of payment.

We estimate your portions to the best of our ability based off of the information provided from your insurance company. It is essentially your responsibility to be aware of your coverage. If you have any further questions, please contact your insurance company directly for your benefits.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents(if any).

How will you be paying for this today?

Check one:

- ☐ Cash
- ☐ Credit
- ☐ Care Credit
- ☐ Check
- ☐ Insurance

_____ _____

Patient Signature, Parent, or Guardian Date

Patient/Doctor Responsibility & Consent

I, _____ understand that on the following procedures

including but not limited to: restorations (fillings, crowns, onlays, inlays), dentures, partial dentures, periodontal surgery (including crown lengthening), and endodontic therapy, I am fully responsible for the maintenance and any care of the teeth/site. If a problem occurs, every possible and reasonable accommodation will be made to allow me into the practice to examine the tooth/site.

In the event deemed necessary to replace or repair any of the work originated and completed by Dr. Ala Dean Attar and associates, he will maintain full responsibility if and only if the problem is a result of his workmanship, contracted lab or product used in treatment/repair.

I understand that each case is very specific and different and I will need to contact the office for an appointment in order to be examined properly by Dr. Ala Dean Attar and for him to evaluate and correct the matter. I understand that matters that fall under this policy will not be rectified through a telephone conversation.

I understand that many times crowns are recommended instead of large restorations/fillings. In the event a specific treatment is recommended and I elect an alternative treatment, I maintain full responsibility for my informed decision and release Dr. Ala Dean Attar from any liability.

The proposed treatment procedures, risks involved with such treatment, alternatives to those procedures and risks of the alternatives, and the risks of no treatment have been explained to me and I understand those explanations. I have been given an opportunity to ask questions and have had those questions answered.

Based on those explanations, I consent to treatment and:

a) Authorize the administration of local anesthesia and/or nitrous oxide and oxygen analgesia deemed necessary for the performance of the above procedure(s).
b) Authorize the collection and use of fluids, hopeless teeth after extraction, and tissue samples after surgery to be used for complimentary diagnosis, documentation, and study.

I understand that there are no guarantees that the proposed treatment(s) will accomplish their intended purpose.

_____ _____

Patient Signature, Parent, or Guardian Date

Release of Confidential Information

I, _____hereby give my consent to Dr. Ala Dean Attar, D.M.D, and associates and to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the clinic. I also understand that I will not be able to revoke this consent in cases where the clinic has already relied on it to use or disclose my health information. Written revocation of consent must be sent to Dr. Ala Dean Attar, D.M.D.

_____ _____

Patient Signature, Parent, or Guardian Date