Nawar Taha DDS PLLC

www.TheToothBoothDental.com

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Welcome to our Practice

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ Last ____________ First ____ MI ____________ Preferred Name

Title: ____________ Mr/Ms/Mrs/etc **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other

Birth Date: ____________ **SS#:** ____________ **Prev. Visit:** ____________

Email Address: ____________ **Best time to call:** ____________

Phone: ____________ Home ____________ Mobile ____________ Work ____ Ext ____________ Fax ____________ Other

Address: ____________ Address 1 ____________ Address 2

____________ City ____ State ____________ Zip Code

I prefer to be contacted by

☐ Cell Phone ☐ Text ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

____

In an emergency, who should be notified? Please enter name, phone number and relationship below

____

Employer Name

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: Phone:

Employer Address:

Address 1 Address 2

City State Zip Code

Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name:

Last First MI Preferred Name

Title: Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Mr/Ms/Mrs/etc

Birth Date: SS#: DL#:

Email Address: Best time to call:

Phone:

Home Mobile Work Ext Fax Other

Address:

Address 1 Address 2

City State Zip Code

Primary Dental Insurance

Name of Insured: Last First MI

Insured's Birth Date: **ID #:** **Group #:**

Insured's Address: Address 1 Address 2

City State Zip Code

Insured's Employer Name:

Employer Address: Address 1 Address 2

City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name:

Insurance Address: Address 1 Address 2

City State Zip Code

Insurance Authorization

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Do you have secondary dental insurance? ○ Yes ○ No

Medical Information

Please check all that apply:

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

Please list any other medical conditions you may have that are not listed:

Please list any medications you are taking (including vitamins):*

Dental Information

How would you rate the condition of your mouth?

○ Excellent ○ Good ○ Fair ○ Poor

Previous Dentist Name and Phone Number

Approximate date of most recent dental exam and/or dental x-rays

I routinely see a dentist every

○ 3 mos ○ 4 mos ○ 6 mos ○ 12 mos ○ Not routinely

What is your immediate concern about your dental health?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply

- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Experiences dry mouth
- ☐ Avoid brushing any part of your mouth
- ☐ Whitened or bleached your teeth
- ☐ Difficulty chewing
- ☐ Currently or previously wore a bite appliance
- ☐ Diagnosed and/or treated for gum disease
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Teeth become loose on their own (without injury)
- ☐ Snores or wakes up frequently during the night
- ☐ Had trouble getting numb
- ☐ Had/Have braces or orthodontic treatment
- ☐ Sensitive to hot, cold, biting, sweets
- ☐ Food gets trapped between any teeth
- ☐ Experienced popping and/or clicking of your jaw joint
- ☐ Clenching or grinding of teeth
- ☐ Gums bleed when brushing or flossing
- ☐ Bone loss around your teeth
- ☐ Experienced gum recession
- ☐ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

HIPAA Acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this dental practice to release any financial or dental information to the following person(s) listed below:

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Name of Patient, Parent or Guardian completing this form:

Relationship to patient: