PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

PATIENT # _____

DATE _____

NAME _____ (FIRST MI LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY

Email: _____

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____ WORK PHONE _____

ADDRESS _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X _____

SIGNATURE OF PATIENT OR PARENT IF MINOR

PATIENT NAME _____ TODAY'S DATE _____

HOME ADDRESS _____ DATE OF BIRTH _____

_____ HOME PHONE _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

_____ SOC. SEC. NO. _____

PATIENT NAME

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE?	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____		
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	☐	☐
6. ARE YOU WEARING CONTACT LENSES?	☐	☐

7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY.

_____

_____

8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____

9. WOMEN ONLY:	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

- ☐ HIGH BLOOD PRESSURE
- ☐ HEART ATTACK
- ☐ RHEUMATIC FEVER
- ☐ SWOLLEN ANKLES
- ☐ FAINTING / SEIZURES
- ☐ ASTHMA
- ☐ LOW BLOOD PRESSURE
- ☐ EPILEPSY / CONVULSIONS
- ☐ LEUKEMIA
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ CARDIAC PACEMAKER
- ☐ HEART MURMUR
- ☐ ANGINA
- ☐ FREQUENTLY TIRED
- ☐ ANEMIA
- ☐ EMPHYSEMA
- ☐ CANCER
- ☐ ARTHRITIS
- ☐ JOINT REPLACEMENT OR IMPLANT
- ☐ CHEST PAINS
- ☐ EASILY WINDED
- ☐ STROKE
- ☐ HAY FEVER / ALLERGIES
- ☐ TUBERCULOSIS
- ☐ RADIATION THERAPY
- ☐ GLAUCOMA
- ☐ RECENT WEIGHT LOSS
- ☐ LIVER DISEASE
- ☐ HEART TROUBLE
- ☐ KIDNEY DISEASES
- ☐ AIDS OR HIV INFECTION
- ☐ THYROID PROBLEM
- ☐ HEPATITIS / JAUNDICE
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ STOMACH TROUBLES / ULCERS
- ☐ RESPIRATORY PROBLEMS
- ☐ OTHER _____

COMMENTS

_____

_____

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ☐
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? ☐
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? ☐
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? ☐
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? ☐
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? ☐
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?
   - A) CLICKING? ☐
   - B) PAIN (JOINT, EAR, SIDE OF FACE)? ☐
   - C) DIFFICULTY IN OPENING OR CLOSING? ☐
   - D) DIFFICULTY IN CHEWING? ☐
8. DO YOU HAVE FREQUENT HEADACHES? ☐
9. DO YOU CLENCH OR GRIND YOUR TEETH? ☐
10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY? ☐
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? ☐
12. HAVE YOU HAD ANY ORTHODONTIC WORK? ☐
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? ☐
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? ☐
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? ☐

I certify that I have read and understand the above information, to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____ _____

PATIENT, PARENT OR GUARDIAN DATE

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPPA) requires that the office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in future.

To comply with one of HIPPA's requirement we are giving you a copy of our Notice of Privacy Practices. This notice of Privacy Practices contains the information that HIPPA requires us to disclose regarding our privacy practices.
From time to time it may be necessary for us to make disclosure of your information in connection with our treatment. For example, we may make a referral or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today either received or reviewed copy of our privacy practices.
I acknowledge that I have today received a copy of the Notice of Privacy Pratices.

_____ _____
Patient Signature Patient name (please print)

I am also signing for my minor children: _____
(please print name)

Date:_____

Patient Consent

Please sign this form below to consent to our disclosure of your informationthat we deem necessary in order to provide you with proper treatment.
I consent to your disclosure of my information, which you deem are necessary in connection with my treatment. I understand that such disclosure may not be of the type listed above.

_____
Patient Signature

I am also signing for my minor children:_____

I also give consent for my treatment to be discussed with the following individuals:(e.g. spouse,parent, adult child, caregiver)

_____
(please print names)

_____

I also give my permission for information regarding_____apptointments, ____Ins. Benefits_____ Financial arrangements to be discussed with the above individuals except:_____

Date:_____

For office use only

Patient refuse to sign. The following circumstances prohibited the patient from signing the Acknowledgement

_____

An emergency situation preented the patient (parent/guardian) from signing.

_____ _____
Office Personnel (signature) Date

Kalil Abraham, D.D.S., F.A.G.D., F.I.C.O.I
Cosmetic-Orthodontics-Implants

Financial Policy

Printed Patient Name Date of Birth Chart Number

Thank you for choosing our practice. If you have any questions or concerns about our office/ payment policies, please do not hesitate to ask our office personnel. We ask that all patients read and sign our Financial Policy as well as complete Patient Information Forms prior to seeing the doctor.

APPOINTMENTS: Our office reserve the right to charge your account $35.00 for any missed/ canceled/ rescheduled appointments with less than **48 hours notice.**

COLLECTIONS: The patient's portion of payment, as well as any past due balances, is due at the time of services are rendered unless prior arrangements have been made. We accept cash, personal checks, Master Card, Visa, Discover, American Express and Care Credit. If you wish to be billed there will be a $10 charge added to your office visit charge (s).

We participate with Delta Dental PPO/ EPO, Dentemax, Cigna, Guardian and MetLife. **It is YOUR responsibility to check which services are covered under your insurance plan**; however, you must understand that:

- Your insurance policy is a contract between you, your employer, and the insurance company. Our relationship is with YOU, not with your insurance carrier.
- All charges are YOUR responsibility whether your insurance company pays or not.
- Fees for service, co-payments and unpaid deductibles are due at the time of service. See paragraph 2 above.
- If the insurance company does not pay our balance within 60 days, we may ask you to contact them to request prompt payment. Please inform us of their response.
- Billed balance over 30 days will be charged a **1.5% rebilling fee**. Billed balance over 60 days will again be a charge of **1.5% rebilling fee**.
- Billed unpaid **balance over 90 days are subject to a $30.00 collection fee** and will be sent to small claims court, an attorney, and/ or Collection Agency.*
- Returned checks are subject to a $35 collection charge: we will notify you by mail. If your outstanding balance is not paid within 10 days, it may be subject to formal collection action as detailed above.

*We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us that we can assist you in the management of your account.

Authorization to Release and Assign Benefits: I authorize release of any information required to act on any Insurance claim and permit photographic, electronic or other facsimile reproduction of the authorization to be used in place of original assignment. I hereby assign to Kalil Abraham, DDS, FAGD, FICOI the dental benefits I am entitled from my insurance company. The authorization is in effect for all future claims, until I choose to revoke it in writing.

I understand that I am financially responsible for all charges incurred as described above. I, the undersigned, understand and agree to be bound by the Financial Policy.

Patient Signature (or Parent/Guardian is Patient is a Minor)_____

Date_____

Authorized Witness (Office Staff of Kalil Abraham DDS, FAGD, FICOI) _____

Patient Communication Preferences

To our Valued Patients:

We are updating our records to determine the best way to communicate with you regarding treatment and appointments in our practice, as well as information regarding your dental health.

Please let us know your preferred method for receiving messages from us:

- Cell phone-number_____
- Home phone- number_____
- Work phone- number_____
- Email:_____

In the event you cannot be reached by phone, is there someone we may leave a message with? (e.g. Spouse, partner) Name:_____

Relationship: _____ Phone number:_____

May we send text messages to you regarding your appointments? _____Yes_____NO

Please send text messages to (number)_____

May we send email messages to you regarding your appointments? _____Yes ____NO

Would you like to receive electronic newsletter from our practice? _____Yes _____NO

_____ _____

Name Signature

_____

Date