Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ___/___/___ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Child's Home #: (____)_____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

Email Address: _____

2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Is child adopted? ☐ Yes ☐ No Is child in a foster home? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Other siblings seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Parent's Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered ☐ Separated

3 Parent's Information

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ___/___/___

Email Address: _____

Cell #: (____)_____ Hm #:(____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

☐ **Father** ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ___/___/___

Email Address: _____

Cell #: (____)_____ Hm #:(____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____
City State Zip

Wk #: (____)_____ Ext: _____ Hm #: (____)_____

Employer: _____

DL #: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____)_____ Ext: _____ Hm #:(____)_____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

6 Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #:(____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

7 Why did you bring the child to the dentist today? _____

Has the child ever had a serious / difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ☐ Yes ☐ No

Please list all drugs that the child is currently taking:

_____

_____

Aside from items listed below, list all drugs/things the child is allergic to:

_____

_____

Latex ☐ Yes ☐ No Metals/Nickel ☐ Yes ☐ No Plastic ☐ Yes ☐ No

8 Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Handicaps / Disabilities
Y	N	ADD / ADHD	Y	N	Hearing Impairment
Y	N	Anemia	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	Hives
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Cancer	Y	N	Kidney / Liver Problems
Y	N	Chicken Pox	Y	N	Measles
Y	N	Congenital Heart Defect	Y	N	Mononucleosis
Y	N	Convulsions	Y	N	Rheumatic / Scarlet Fever
Y	N	Diabetes	Y	N	Sickle Cell Disease / Traits
Y	N	Epilepsy	Y	N	Skin Rash
Y	N	Exposed to HIV, but Neg.	Y	N	Tuberculosis (TB)

Are the Child's Immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems that the child has had: _____

_____

Does/did the child experience any of the following?

Y	N	Lip Sucking / Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb / Finger Sucking

Was the child breast fed? ☐ Yes ☐ No

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

My method of payment will be: _____

_____
Signature of parent or guardian Date

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

verbally reviewed the medical / dental information above with the parent / guardian & patient named herein. Initials: _____ Date: _____

Doctor's Comments:

_____

_____

_____

_____

Medical History Update

1. Date: _____ **Signature:** _____

Comments: _____

_____

2. Date: _____ **Signature:** _____

Comments: _____

_____

FINANCIAL ARRANGEMENTS

Our goal in discussing financial arrangements relative to your dental needs includes:

- To inform you of treatment alternatives
- Their respective advantages and disadvantages
- The consequences and/or risks of limited delayed treatment and/or non-treatment

We will discuss with you the costs of the dental treatment and alternative treatment. We will gladly answer your questions until you are completely satisfied.

In our efforts to keep dental costs at a minimum while maintaining a high level of professional care, we have established the following polices:

Dental Insurance:

We are happy to assist you in receiving your maximum dental insurance benefits. Dental insurance is a contact between your employer, who selected your coverage limits, and the insurance company. You (the subscriber) will receive the dental benefits as defined within this plan. Insurance payments received by this office will be credited to your account or refunded to you in the case of an overpayment. We cannot guarantee insurance carrier payments on office-generated insurance reimbursement estimates. You are responsible for all dental fees (charges) that your insurance company has not paid for whatever reason, within a 60-day period from when treatment is begun. You will be expected to pay the full amount due.

Our office will accept assignment of dental insurance benefits directly to our office. Please bring your dental plan benefits booklets to our office to allow our staff to make a reasonable estimate of what insurance company will pay for a given dental procedure. For an exact statement of benefits, a predetermination of benefits form can be sent to the insurance company. This process requires a dental insurance form with a section of the form completed to be used to request a predetermination of benefits from your insurance carrier. The insurance carrier will return the form stating their payment and your co-payment responsibility.

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Money Order and Care Credit Plan upon approval.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

I understand that the fee estimate listed for any proposed dental care can only be extended for a period of 90 days from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

I grant my permission to Oasis Dental Clinic and/or Oasis Dental Clinic's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form. I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect on this account.

APPOINTMENT AGREEMENT

At Oasis Dental Clinic, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 24 hours so we are able to assist other patients with their dental needs.

We truly appreciate your understanding. Our goal at Oasis Dental Clinic is to be your partner in health and to assist you in keeping your teeth for a lifetime.

By signing below, I agree to fulfill my obligation as a patient at Dental Concepts and agree to honor my appointment time.

We hope this information is helpful in answering some of the questions you may have regarding our office polices. Please feel free to discuss any questions you may have with us.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date Relationship to Patient

Signature of guarantor of payment/responsible party Date Relationship to Patient

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail:_____

Patient #: _____ Social Security#: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. . We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Oasis Dental Clinic (Dr. Ali Azad)

Telephone: (240) 246-7900 FAX: (240) 246-7479

Address: 19533 Doctors Drive, Germantown, Maryland 20874

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____--

Relationship to Patient: _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include complete Consent in the patient's chart

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoke my Consent.

Signature: _____ Date: _____