Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Personal Information

Date_____

Birthday_____

SS#/SIN_____ E-mail_____

Name_____

Wishes to be called_____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address_____

City_____ State/Prov._____ Zip/P.C._____

Employer_____ Occupation_____

Referred by_____

Home Phone_____

Work Phone_____ Ext #_____

Cell Phone_____

Emergency Contact Number_____

Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ❒ Soft ❒ Medium ❒ Hard

	YES	NO
5. Do your gums bleed while brushing?	❒	❒
6. Do your gums bleed when flossing?	❒	❒
7. Do you feel pain to any of your teeth when brushing or flossing them?	❒	❒
8. Are your teeth sensitive to hot, cold, sweet or sour foods/liquids?	❒	❒
9. Have you noticed any loosening of your teeth?	❒	❒
10. Does food tend to become caught between your teeth?	❒	❒
11. Do you have any sores or lumps in or near your mouth?	❒	❒
12. 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?	❒	❒

	YES	NO
13. Have you had any head, neck, or jaw injuries?	❒	❒
14. Do you have frequent headaches?	❒	❒
15. Do you clench or grind your teeth while awake or asleep?	❒	❒
16. Do you bite your lips or cheeks frequently?	❒	❒
17. Have you ever had:		
a. Orthodontic treatment (braces)?	❒	❒
b. Oral surgery?	❒	❒
c. Gum treatment?	❒	❒
d. Your teeth ground or the bite adjusted?	❒	❒
e. Worn a bite plane or other appliance?	❒	❒
18. Are you satisfied with the appearance of your teeth?	❒	❒
19. Have you ever had an upsetting experience in the dental office?	❒	❒
20. Is there anything about having dental treatment that bothers you?	❒	❒

Medical History

Although dental personnel primarily treat the area in and around your mouth, you mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health?	❒	❒
2. Have there been any changes in your general health within the past year?	❒	❒
3. Date of your last physical exam: _____		
4. Physician's name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician?	❒	❒
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain. _____	❒	❒
7. Are you taking any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? _____	❒	❒
8. Have you ever taken Fen-Phen/Redux?	❒	❒
9. Have you had any abnormal bleeding?	❒	❒
10. Do you bruise easily?	❒	❒
11. Have you ever required a blood transfusion?	❒	❒
12. Have you had a recent weight loss?	❒	❒
13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❒	❒
14. Do you use tobacco?	❒	❒
15. Do you use alcohol or cocaine or other drugs?	❒	❒
16. Are you wearing contact lenses?	❒	❒
17. Do you have any disease, condition or problem not listed above that you think I should know about?	❒	❒

Women Only:

1. Are you pregnant or think you may be pregnant?	❒	❒
2. Are you nursing?	❒	❒
3. Are you taking birth control pills?	❒	❒

Are you allergic to or have you had reactions to:

1. Local anesthetics like novocaine?	❒	❒
2. Penicillin or other antibiotics?	❒	❒
3. Sulfa drugs?	❒	❒
4. Barbiturates, sedatives or sleeping pills?	❒	❒
5. Aspirin?	❒	❒
6. Iodine?	❒	❒
7. Other? _____	❒	❒

Do you have or have you ever had the following:

1. Rheumatic heart disease or rheumatic fever?	❒	❒
2. Scarlet fever?	❒	❒
3. Heart defect or heart murmur?	❒	❒
4. Heart trouble, heart attack, or angina?	❒	❒
a. Do you have pain in your chest upon exertion?	❒	❒
b. Are you ever short of breath after mild exercise?	❒	❒
c. Do your ankles swell?	❒	❒
d. Do you get short of breath when you lie down?	❒	❒
e. Do you require extra pillows when you sleep?	❒	❒
5. Pacemaker?	❒	❒
6. Heart Surgery?	❒	❒
7. High blood pressure?	❒	❒
8. Low blood pressure?	❒	❒
9. Hepatitis, jaundice or liver disease?	❒	❒
10. Stroke?	❒	❒
11. Sinus trouble?	❒	❒
12. Lung or breathing problems?	❒	❒
13. Asthma or hay fever?	❒	❒
14. Hives or skin rash?	❒	❒
15. Fainting spells or seizures?	❒	❒
16. Diabetes?	❒	❒
17. AIDS or HIV infection?	❒	❒
18. Thyroid problems?	❒	❒
19. Allergies?	❒	❒
20. Arthritis or rheumatism?	❒	❒
21. Joint replacement or implant?	❒	❒
22. Stomach ulcer?	❒	❒
23. Kidney trouble?	❒	❒
24. Tuberculosis?	❒	❒
25. Persistent cough?	❒	❒
26. Cough that produces blood?	❒	❒
27. Cancer?	❒	❒
28. Sexually transmitted disease?	❒	❒
29. Epilepsy?	❒	❒
30. Anemia?	❒	❒
31. Leukemia?	❒	❒
32. Glaucoma?	❒	❒

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information ca be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

Dental Insurance Information

Primary Insurance

Name of Insured_____

Relationship to patient_____

Insured's birthdate_____

SS#/SIN_____

Employer_____

Date Employed_____

Occupation_____

Insurance Company_____

Group #_____

Employee/Cert #_____

Ins. Co. Address_____

Deductible_____

Amount already used_____

Max. annual benefit_____

Additional Insurance

Name of Insured_____

Relationship to patient_____

Insured's birthdate_____

SS#/SIN_____

Employer_____

Date Employed_____

Occupation_____

Insurance Company_____

Group #_____

Employee/Cert #_____

Ins. Co. Address_____

Deductible_____

Amount already used_____

Max. annual benefit_____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or parent/guardian if minor

Date

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: _____