HEALTH HISTORY & REGISTRATION

PATIENT'S INFORMATION

Name: _____E-Mail :_____

Social Security #: _____Date Of Birth: _____

Residence: _____ City: _____ State_____ Zip Code: _____

Mailing Address: _____ City: _____ State _____ Zip Code: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Employer: _____Occupation: _____ How did you hear about us?_____

Would you like us to file your insurance claims on your behalf? _____

POLICYHOLDER'SINFORMATION(Providing this information doesn't relieve you from your financial responsibility towards treatments rendered)

Name: _____E-Mail :_____

Social Security #: _____Date Of Birth: _____ Relation To Patient: _____

Residence: _____ City: _____ State_____ Zip Code: _____

Mailing Address: _____ City: _____ State _____ Zip Code: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Employer: _____ Occupation: _____

DENTAL INSURANCE INFORMATION*(Providing this information doesn't relieve you from your financial responsibility towards treatments rendered)*

Insurance Company: _____ Insurance Company Telephone: _____

Group Number: _____Subscriber ID number: _____

AUTHORIZATION

I authorize and give informed consent to my dental provider to perform agreed upon procedures that isnecessary for proper diagnosis and dental care. These may include but are not limited to, diagnostic(radiographs and oral exams), therapeutic procedures, local anesthesia and the use of other medications. I confirm that the information on this page and the medical history are correct to the best of my knowledge. I hereby authorize insurance payments to go directly to the dental office. Should I receive payment from insurance company in error, I will forward that payment to Bethesda Dental Health upon receipt.**I understand that I am responsible for the cost of the treatment and services rendered regardless of my insurance benefits.**
I also authorize Bethesda Dental Health to discuss my protected health and account informationwith the persons listed below:

Name and Relationship: _____

Patient/ Legal Guardian/Parent Signature_____Date_____

Patient's Name:

DENTAL HISTORY

How long has it been since you last saw a dentist? _____

What did you have done at that time? _____

What is the reason for today's visit? _____

Date of last dental x-rays? _____ When was your last dental cleaning?_____

Do you want whiter teeth? _____Is there anything you would like to change about your smile? _____

Have you been told that you grind your teeth? ____ Are your facial muscles sore or tense when you wake up?_____

Are your teeth or gums sensitive?_____ Do you wear dentures? _____ How long have you had them?_____

MEDICAL HISTORY

Do you have or ever had?

Yes___ No___ Arthritis

Yes___ No___ Diabetes

Yes ___No___ Convulsions /Dizzy Spells

Yes___ No___ Heart Surgery

Yes ___No___ HIV Positive/AIDS

Yes ___ No___ Sexually Transmitted Diseases

Yes ___ No___ Cancer

Yes___ No___ High Blood Pressure

Yes___ No___ Epilepsy

Yes___ No___ Jaundice/Liver Disease

Yes___ No___ Kidney Problems/Dialysis

Yes___ No___ Tuberculosis

Yes___ No___ Joint Replacement (including hip)

Yes___ No___ Rheumatic Fever

Yes ___ No___ Stroke

Yes___ No___ Heart Murmur requiring premedication

Yes___ No___ Mitral Valve Prolapse

Yes___ No___ Hepatitis A,B,C

Yes___ No___ Asthma/Breathing Problems

Yes___ No___ Low Blood Pressure

Yes___ No___ Hyperthyroid/Hypothyroid

Yes___ No___ Radiation Therapy

Yes___ No___ Bleeding Disorder

Yes___ No___ Other_____

Have you had any reactions to local anesthetic (Novocain)? _____

Are you allergic to? ____Aspirin ____Sulfa ____ Codeine ____Penicillin ____ Other_____

Are you under the care of a physician? Yes/No If yes please explain_____

_____

Are you currently taking any medications (prescriptions or over the counter, i.e., aspirin, birth control pills)? Yes/No

If yes, please list all medications: _____

FEMALE PATIENTS

Are you pregnant? Yes/No If yes, due date: _____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Bethesda Dental Health

General & Cosmetic Dentistry
Sheida Larijani, D.D.S.

7978 Old Georgetown Rd,
Suite 6C
Bethesda, MD 20814
Tel: (301) 654-1887

Financial & Insurance Policies

We would like to take this opportunity and welcome you to our practice. Our goal is not only to treat you, but also to educate you as how to prevent dental disease. Our mission is to provide you the highest quality dental care in a pleasant surrounding as efficiently as possible. Please read and sign the following:

Insurance Policy:

- Insurance companies never guarantee payment. It is your responsibility to be familiar with restrictions, limitations and deductions that may apply to your plan and whether or not we are participating with your insurance. Your estimated coinsurance and deductible is due at the time the treatment is rendered. Your dental insurance is a benefit that you or your employer purchases from your insurance carrier. As a courtesy to you, we will submit claims to your insurance company. You are still the responsible party to pay for dental treatment.
- Please keep in mind that the quoted amount of coinsurance is **approximated** based on the information received from your insurance company which may or may not be accurate. All claims that are rejected or adjusted by the insurance company will become your additional responsibility and payable to *Bethesda Dental Health* immediately.
- If *Dr. SheidaLarijani*or the associate doctors are not participating with your insurance, payment is expected in full at the time of service unless prior arrangements have been made. We will provide you with statement of services rendered to submit to your insurance carrier once the balance is paid in full.
- All insurance claims not paid within 60 days of date of service are due and payable immediately.

Financial Policy:

- ***We are available for you after hours and on Saturdays*** if you have an emergencytherewill be a charge of $375.00 in addition to your treatment fees.
- ***We offer no-interest financing*** for extensive treatment over the amount of $1,000.00. Financing is subject to approval by the participating financial group. For your convenience, we accept Cash, Master Card, and Visa.
- ***Balances over 60 days old*** will accrue an interest charge of **1.5% monthly** or **18% annually. $15.00 monthly late fee** will also be added to your statement if payment is not received**.** If it becomes necessary to refer your account to collection agency, you will be responsible for all expenses including but not limited to court costs, reasonable attorney's fees(40%) and an account service fee of $35.00.
- ***Returned checks*** are subject to a $50.00 service charge.
- ***Broken and cancelled appointments*** are subject to $50.00 per half hour. Forty-eight(business) hour notice is required to avoid such charges.
- ***Procedures that involve laboratory work*** i.e. crowns, dentures….If you fail to maintain your appointment for delivery of your case, you are responsible for laboratory fees in full and 50% of all procedure fees.
- ***All patients*** under the age of eighteen **MUST** be accompanied by a parent or legal guardian. A parent or legal guardian **MUST** remain on site while treatment is rendered.
- ***Copies of your x-rays and records*** are available at you request. We require a written request forty-eight hours prior. There is 65 cents charge per page for your records and $15 processing fee for copies of your most recent x-rays.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian Date

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 out 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 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: Sheida Larijani, D.D.S.

Telephone: 301-654-1887 Fax: 301-654-1880

E-mail: none.

Address: 7978 Old Georgetown Road Suite 6C Bethesda, MD 20814

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 Contact Person 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.

SIGNATURE

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 ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed 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 revoked my Consent.

Signature: _____ Date: _____

General Consent for Examination and Treatment

I hereby consent to having dental radiographs and performing treatment upon

_____ by Bethesda Dental Health.
(Patient Name)

Such treatment will be explained to me and will not proceed without my verbal acceptance. I reserve the right to ask specific questions before recommended treatment commences. The nature and purpose of the treatment rendered, benefits, risks, and alternative methods of treatment will be fully explained to me. No guarantee, warranty, or assurance has been given to me that the treatment will be successful or to my complete satisfaction. This consent pertains to treatment rendered upon said patient while in the physical office of Bethesda Dental health.

Photographs

Bethesda Dental Health may take photographs for certain procedures. These photographs are used for planning your treatment, insurance, laboratory, patient education, and advertising purposes. Photographs will not be taken without verbal consent from the patient. All photographs and/or duplications are property of Bethesda Dental Health.

_____ _____

Signature of Patient or Legal Guardian Date