WELCOME!

SO THAT WE MIGHT BECOME BETTER ACQUAINTED, PLEASE COMPLETE THE FOLLOWING:

Advanced Dental Spa

Vivianne Khalife-Yazbeck, DDS

Raed Yazbeck, DDS

140 Dartmouth Street New Bedford, MA 02740 Tel: (508) 717-0554

373New Boston Road, Fall River, MA 02720 Tel: (508) 567-4544

ADULT PATIENT INFORMATION

Today's Date: _____

Name: _____ ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. I prefer to be called:_____
Last First Mi

❑ Male ❑ Female Birthdate: _ADS_____ Age: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Social Security # _____ Home Address: _____
Street City State Zip

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____ Driver License #: _____

Where & When are best times to reach you: _____ Other Family Members seen by us: _____

E-mail Address: _____ I would like to be contacted for appointments via: ❑ Email ❑ Text Message ❑ Phone

Patient or Parent/Guardian's Employer: _____ Employer Phone #: _____ Occupation: _____

Employer Address: _____
Street/PO Box City State Zip

Whom may we Thank for referring you? ❑ Insurance ❑ Newspaper ❑ Post Card ❑ Family: _____ ❑ Patient: _____ ❑ Other: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Relation: _____ Home Phone #: _____ Social Security #: _____

Employer: _____ Work Phone #: _____ Driver License #: _____

Billing Address: _____
Street/PO Box City State Zip

Is this person currently a Patient in our Office? ❑ Yes ❑ No

PRIMARY INSURANCE INFORMATION

DENTAL COVERAGE ❑ YES ❑ NO MEDICAL COVERAGE? ❑ YES ❑ NO

Patient's relationship to subscriber: ❑ Self ❑ Spouse Is this person a patient here? ❑ Yes ❑ No

Insurance Co. Name: : _____ Phone #: _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Policy Holder's Name: _____ Social Security #: _____ Birthdate: ____/ ____/ ____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

SECONDARY INSURANCE INFORMATION

DENTAL COVERAGE ❑ YES ❑ NO MEDICAL COVERAGE? ❑ YES ❑ NO

Patient's relationship to subscriber: ❑ Self ❑ Spouse Is this person a patient here? ❑ Yes ❑ No

Insurance Co. Name: : _____ Phone #: _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate: ___/ ___/ ___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

IN CASE OF EMERGENCY

Name of local friend of relative (not living at same address): _____ Relationship to Patient: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____ Address: _____

Payment is due in full at the time services are performed unless prior arrangements have been approved. We accept Cash, Check, MasterCard, Visa, Discover and Debit Cards. For extensive services we offer low and **no interest** payment plans through Care Credit. Initials: _____

Please turn over for more on the back...

DENTAL HISTORY

What is the reason of your visit today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Previous Dentist: _____ Last visit Date: _____

Last Cleaning Date: _____ Frequency: _____

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Do you use fluoridated toothpaste? ❑ Yes ❑ No

Primary source of drinking water? ❑ City Water ❑ Bottled Water ❑ Well Water

Are your teeth sensitive to: ❑ Hot? ❑ Cold? ❑ Pressure? ❑ Sweet?

Have you had treatment for gum disease? ❑ Yes ❑ No

Have you had orthodontic treatment (braces)? ❑ Yes ❑ No

Do you wear a denture(s) or partial denture(s) ❑ Yes ❑ No

Do you have mobility in your teeth?

Do you have dry mouth/excessive thirst? ❑ Yes ❑ No

Do you have mouth odors/bad taste? ❑ Yes ❑ No

Do you get cold sores/blisters/oral lesions? ❑ Yes ❑ No

Do you have clenching or grinding habits? ❑ Yes ❑ No

Do you get food catches between teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

MEDICAL HISTORY

Are you currently under the care of a physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____

Street City State Zip

Phone #: _____ Date of Last Visit: _____/ _____/ _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Previous Attempts to quit ❑ Yes ❑ No Number of Attempts: _____

Are you interested in quitting smoking? ❑ Yes ❑ No

Former tobacco User? ❑ Yes ❑ No Amount: _____ Year Quit: _____

Are You allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Sedatives
Y	N	Barbiturates	Y	N	Penicillin	Y	N	Latex
Y	N	Codeine	Y	N	Tetracycline	Y	N	Metals
Y	N	Dental Anesthetics	Y	N	Sulfa Drugs	Y	N	Nuts

List other: _____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Current Medications (Prescription, Over the counter and Herbal)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Do you or have you experienced the following?

Y N Abnormal bleeding	Y N Cholesterol	Y N Hay Fever	Y N Kidney Problems	Y N Scarlet Fever
Y N Alcohol Abuse	Y N Colitis	Y N Headaches	Y N Low Blood Pressure	Y N Shingles
Y N Anemia	Y N Congenital Heart Defect	Y N Heart Attack	Y N Lupus	Y N Sickle Cell Disease
Y N Arthritis	Y N Diabetes	Y N Heart Murmur	Y N Liver Disease	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Valves	Y N Drug Abuse	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Emphysema	Y N Hepatitis ❑ B ❑ C	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Epilepsy	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Glaucoma	Y N Hospitalized for Any Reason	Y N Seizures	Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: _____

I affirm that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes. I authorize the dental staff to perform the necessary dental services I may need.

Signature: _____ Relationship to Patient: _____ Date: _____

Office Use ONLY

ASA: ❑ I ❑ II ❑ III ❑ IV ❑ V **Medical Consult needed ❑ Yes ❑ No** **Referred To:** _____

Reviewed By: _____ **Reviewed By:** _____ **Date:** _____

Comments: _____

APPOINTMENT POLICY

We do our best to keep the cost of your dental treatment as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us with 24 hours notice, another patient who could have been seen was not. This adds to the overall cost of care, as trained personnel and dental facilities are not being used.

As a result we find it necessary to charge **$50.00 fee** for broken appointments without 24 hour notice, and you will be dismissed from our office.

PATIENTS WITH PRIVATE DENTAL INSURANCE

You will need to supply us with the employee information (name, date of birth, social security number, employer and ID #) as well as the name and address of the insurance company. We will do our best to answer any questions you may have about our insurance coverage but we always suggest that you call or visit your insurance company's website.

As a courtesy to our patient, we will gladly submit the insurance claim to your insurance company. We will collect your estimated copayment and deductible at each visit. We make every effort to determine your insurance benefits when you receive treatment but consider your copayment an estimate until we receive payment from you insurance company

Please remember that any information we provide to your insurance coverage is our best ESTIMATE and not a guarantee of the payment that will be received.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I have read and understand the office policies.

Patient Name: _____Signature: _____ Date: _____

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION
(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.

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.

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 office. 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.

Patient Name: _____Signature: _____ Date: _____

CONSENT FOR SERVICES

I authorize Drs. Of Advanced Dental Spa or Assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agents (s), including those related to restorative, palliative, therapeutic, or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of al types, teeth may remain sensitive or even possible quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare it is also possible for the tongue, cheek or other oral tissue to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to, crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may in rare cases require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature: _____ Relationship to Patient: _____Date: _____