PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT) Home Phone_____ Cell Phone _____

Patient _____
Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Email_____

Employed by_____ Occupation _____

Business Address_____ Business Phone _____

Spouse/Parent Name_____ Spouse/Parent Birthdate_____

Spouse/Parent Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Who is responsible for this account? _____ Relationship to Patient_____

Social Security #_____ Spouse/Parent Social Security #_____

Name of Dental Insurance Company _____ Group Number _____

In case of emergency, who should be notified? _____ Phone _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (Check boxes that apply):

☐ Heart Murmur
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Circulatory Problems
☐ Nervous Problems
☐ Radiation Treatment
☐ Artificial Heart Valves or Joints
☐ Recent Weight Loss
☐ Back Problems
☐ Diabetes
☐ Respiratory Disease
☐ Epilepsy
☐ Headaches
☐ Hepatitis, Jaundice or Liver Disease
☐ Cancer
☐ Psychiatric Care
☐ Mitral Valve Prolapse
☐ Allergies to Anesthetics
☐ Allergies to Medicine or Drugs
☐ General Allergies
☐ Blood Disease
☐ Arthritis
☐ Special Diet
☐ Swollen Neck Glands
☐ Rheumatic Fever
☐ Sinus Problems
☐ AIDS/HIV
☐ Thyroid Disease
☐ Stroke
☐ Ulcer
☐ Venereal Disease
☐ Chemical Dependency
☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____ If so, what_____
_____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what _____
Are you under the care of a physician? ☐ Yes ☐ No
For what conditions? _____

If patient is a child; what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____
_____
_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

(OVER)

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. FARIBA ASLEMAND_____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor 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.

_____ _____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of minor/child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I acknowledge that payment is due at time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date *Signature of insured/ Guardian*

Patient Liability Agreement

I/we understand that I/we am financially responsible for all bills incurred while under the care of **Fariba Aslemand D.D.S.** In the event that my/our account is not paid I/we shall be liable for any and all cost of collection, including but limited to an additional **50%** fee if my/our account is forwarded to a collection agency for collection. I will further understand that there shall be an **18% interest fee** charged on any outstanding balance. In addition, I/we further understand that I/we may also be responsible for attorney fees. I/we understand that if a check payment is returned there will be a returned check fee applied to my/our account of $55 in addition the balance.

Sign: _____

I/we understand that Family Dental Care has a charge for **infection control** that is due at the time of visit. I/we understand that this is a fee not covered by any dental insurance company and I/we will be responsible for payment of **$15.00**.

Dominion National HMO Plan Members: Your plan has additional copays due at the end of your treatment that will be provided to you before you are seated in the back. All services rendered to you are subject to copay set by Dominion National, please verify with the staff before treatment is rendered. Fees will be collected either before or after being treated. The **infection control** is an additional fee you will be responsible for in addition to the fees set by Dominion.

Sign: _____

If you currently are insured by Medicaid or Medicare this fee does not apply to you and you **DO NOT** need to sign the line above.

FINANCIAL TERMS AND OFFICE POLICIES

We require that all patients call their insurance company and verify their benefits (which include copayments, co-insurance, and deductibles). **Knowing your insurance benefits is YOUR responsibility**. We will bill your insurance; however, you are responsible for copayment amounts and deductibles as set by your plan. **We expect that fees be paid at the time of service.** If for any reason we must bill you for fees, there is a $35 administrative charge for this service. *We reserve the right to refuse to reschedule appointments if account balances are not paid.*

We are required by law to collect all co-pays at the time of service.

Payments for co-pays, co-insurance, deductibles, and other fees are due at the time the service is rendered. If you are unable to meet your financial commitment, you will have to reschedule your appointment.

Missed appointments, disability evaluations, court ordered evaluations, completion of forms attorneys or employers, copies of records, letters or any other type of reports are not covered by your insurance and the charges associated with them are your responsibility. Full payment in advance is required for these services.

Appointment Policies: Please be sure to call or text us 24 hours in advance to cancel or reschedule your appointment. You will be charged a $50 no show fee. Our office is now texting patients a reminder and confirmation text a week ahead of your appointment. Please be sure that we have your most recent telephone number on file to ensure to ensure that you receive the reminder. Appointment reminder calls and texts are attempted as a courtesy for you, but it is your responsibility to keep track of appointment dates and time. Please do not arrive more than 10 minutes early to your scheduled appointment time. We highly recommend that you make a follow up appointment with Dr. Aslemand before leaving the office to ensure that you get in within a timely fashion. Dr. Aslemand's schedule tends to book up rapidly.

WALK INS: **Dr. Aslemand does accept same day emergencies depending on the case and urgency. There may be times when we unfortunately are behind schedule to accommodate patients whom make same day appointments. We ask that those patients coming in same day be mindful of our scheduled patients and understand that if we bring you in you may not be seen at the time we ask you to come in. We must take in our scheduled patients first.**

Letters and Forms: There is a minimum turnaround time of one week (7 business days) for requested records and letters. The minimum fee is **$45 (forty five dollars)** and is not covered by insurance. Please keep in mind that Dr. Aslemand must approve all letters before they are faxed, picked up, mailed, or emailed. The *minimum* turnaround time for letters is one week, so please make sure request letters one week in advance.

DENTAL TREATMENT CONSENT FORM

Patient: _____

By signing below, I understand that:

a) A treatment plan will be presented to me, listing the procedures that will be done.

Initials _____

b) The treatment plan may change during treatment based on conditions found while working on teeth that were not discovered during examination. I give permission to the Dentist to make any changes with further consent.

Initials _____

c) Antibiotics and analgesics (pain medicine) may be prescribed at some point during treatment. These medications have the potential to cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. (Severe allergic reaction)

Initials _____

d) Local anesthesia is required for many dental procedures. Risks of local anesthesia include soreness of the injection site, muscle tenderness, bruising, swelling, and in rare instance nerve damage which can result in prolonged numbness.

Signature: _____ Date: _____

Consent Form for the
Use and Disclosure of Protected Health Information

Patient Name _____ Date of Birth _____

Family Dental Care P.C., Dr. Fariba Aslemand "**Notice of HIPAA Privacy Practices**" provides information about how we may use and disclose protected health information about you/your children. Please acknowledge access to this office's **Notice of HIPAA Privacy Practices** by initialing here: _____

Our **Notice of HIPAA Privacy Practices** states that we reserve the right to change terms described. Should this happen, the notice will be posted in our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized insurance carrier benefits be made on my/my children's behalf to Family Dental Care P.C., Dr. Fariba Aslemand for any services furnished to me by that dentist. I authorize any holder of dental information about me to release to any insurance carriers for which I/my children have coverage, any information needed to determine these benefits for the benefits payable for related services. I understand that copays must be paid at the time of service in accordance with the contracted insurance carrier agreements.

_____

Patient Signature (Signature of parent or guardian) Today's Date

I give permission for the office of Dr. Aslemand to:

1. Send appointment reminders via: text, postcard, email, or voicemail; to the addresses and numbers provided in registration form.
2. Send fax/phone/email patient information; at my request; such as school dental forms and authorization to dispense medication at school, even if confidentiality of this communication cannot be guaranteed.
3. Fax/email dental/health forms, prescriptions, referrals, and/or other materials pertaining to my/my children's care and/or status; at my request, to addresses I have provided.

_____

Patient Signature (Signature of parent or guardian) Today's Date