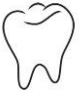
Welcome to Our Office
Hayat Najafe, D.D.S.   Mazin Farah, D.D.S.



Please complete all information requested.

Patient Information

Date______________________________ Name____Age_______Sex_______SSN____________-________-____________
First MI Last
Address____ Apt No.______ City____ State__________ Zip__________________
Birth date ____________-____________-_____________ Occupation____
Full Time Student? ☐ Yes ☐ No School Attending__________________________________ Whom may we thank for referring you? ________________________________
Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnered ☐ Minor
Are any of your family members patients of this practice? Yes ☐ No ☐ Name ____
Spouse's Name____________________________________ Birth date__________-__________-____________ SSN________-______-_________ Phone__________________________

Phone Numbers & Contacts

Cell (_______) _______________________ **Home** (_______) ____________________ **Work** (______) ________________________ Ext.________ **Alt** (_________) _______________
Best time and place to reach you____ **Email Address** ____
In case of emergency contact____Relationship___________________________________ **Phone** (________)__________________

Dental Insurance

Is patient covered by **Secondary** Insurance? ☐ Yes ☐ No

Primary Insurance____
Subscriber's Name ____
Relationship to Patient____
Birth date _______________________ ID # ____________________________
Group # ________________________ Phone (_____)_____________________
Effective Date ____

Subscriber's Name____
Relationship to Patient ____
Birth date_____________________________ ID #____________________________________
Secondary Insurance Company ____
Group # _____________________________ Phone (______)__________________________
Effective Date ____

Dental History

Reason for today's visit____
Previous Dentist ____ Address, Phone# or Email ____
So that we can best serve you, may we ask why you left your last dental office? ____
Date of last dental visit _______________________________ Date of last dental exam ____________________________ Date of last complete x-rays_________________________
Date of last cleaning/prophy ____ Have you ever had any serious problems with past dental treatments? ☐ Yes ☐ No
If yes, Please explain____
How often do you floss? __________________________________ How often do you brush? ___________________________
Have you ever had any problems with past dental treatment? ☐ Yes ☐ No If yes, explain____

Please Check Yes or No to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips, mouth or gums	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No	Orthodontic Treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain, Soreness of Facial Muscles	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal Treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitive to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitive to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitive to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitive when biting or chewing	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No
Do you have Dental Implants?	☐ Yes	☐ No	Are You Happy With Your Smile?	☐ Yes	☐ No

Medical History

Information you may feel insignificant could be directly related to your dental health. Answering all the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all the questions in detail. Remember to include all information even if you feel it's not important or necessary.

Physician's Name: ____ Date of last visit: ____

Do you have or have you ever been treated for?

	Y	N		Y	N		Y	N
Allergies/Hayfever			Drug Addiction			Low Blood Pressure		
Alcohol Addiction			Emphysema			Mitral Valve Prolapse		
Anemia			Epilepsy or Seizures			Nervous Disorders		
Arthritis/Rheumatism			Fainting or Dizziness			Psychiatric Treatment		
Artificial Joints			Gastro-intestinal Problems			Respiratory Disease		
Asthma			Heart Attack/Failure			Sickle Cell Trait		
Back Problems			Heart Disease			Sinus Problems		
Bleeding disorders/Hemophilia			Heart Pacemaker			Smoker		
Cancer or Leukemia			Heart Surgery			Stroke		
Chemotherapy/ Radiation TX			Hepatitis Type_______			Thyroid Problems		
Dementia/Alzheimer's			Herpes			Tuberculosis		
Diabetes			High Blood Pressure			Special Diet		
Dialysis/Kidney Disease			HIV/AIDS			Stomach Ulcers		

Do you need to take an antibiotic premedication prior to dental treatment? YES/NO please circle.

If yes, what antibiotic are you normally prescribed? ____

	Yes	No
Women: Are you pregnant?	☐	☐
Due Date____________________		
Are you nursing?	☐	☐
Taking birth control pills?	☐	☐
Taking hormone medications?	☐	☐

Are you allergic to any of the following?

	Yes	No		Yes	No		Yes	No
Aspirin	☐	☐	Acrylic	☐	☐	Barbiturates	☐	☐
Codeine	☐	☐	Erythromycin	☐	☐	Ibuprofen	☐	☐
Latex	☐	☐	Penicillin	☐	☐	Metals (i.e. gold)	☐	☐
Sulfa	☐	☐	Local Anesthetic	☐	☐	Vicodin	☐	☐

Other known allergies: ____

Please list any current medications now taking: ____

____

Have you ever taken, or are you currently taking any of the following medications?

	Yes	No	
Blood Thinners	☐	☐	
Bisphoshonates	☐	☐	An example of bisphosphonates would be Fosamax, Actonel, Boniva, Zometa, or Reclast

To the best of my knowledge, the above information related to my medical and dental health is complete and correct.

I understand that it is my responsibility to inform my doctor if I, or my child/children have a change in health.

Patient/P*arent/Legal Guardian Signature:* ____ Date: ____________________

I authorize the Dentist(s) or designated staff treating me, to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me. I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorized this practice to submit claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE." I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary And/or requested. I agree to be responsible for payment of all services rendered on my behalf to my dependents. I agree that I am responsible for any unpaid claims. I have been made aware of all financial policies of the office.

Patient Name (Printed)______________________________**Parent/Guardian/PatientSignature:** ______________________________**Date:** ______________

Hayat Najafe, D.D.S Mazin Farah, D.D.S
1740 Carl D. Silver Parkway
Fredericksburg, VA 22401
Phone (540) 548-8878 / Fax (540) 548-8969

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name	
Date of Birth	
Social Security #	

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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

I GIVE PERMISSION TO SHARE APPOINTMENT, BILLING, OR DENTAL INFORMATION WITH THE PERSON NAMED BELOW:
Name: ______________________________ Relationship to this person: ______________________________

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 health care 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 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 changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at:
1740 Carl D Silver Parkway, Fredericksburg VA, 22401 or by phone at (540)548-8878

Right to Revoke You have the right to revoke this Consent at any time by sending written notice of your revocation to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we have taken in reliance on this Consent before we received your revocation. Also, we may decline to treat you or to continue treating you, if you revoke 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: ____________________________

Printed Name: ____

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FINANCIAL POLICIES

In consideration for the professional services rendered now in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus, attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not; plus, court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary. Checks returned by your bank, for any reason, are subject to a $50 bank processing charge in the addition to the amount of the returned check, in form of cash, money order or credit card. As a **courtesy** to our patients upon presentation of valid insurance coverage we call the insurance company to obtain verification of eligibility. We also ask for a basic breakdown of benefits. It is in the patient's best interests to be fully aware of their individual policy as the information provided to us is not always indicative of their personal policy.

The undersigned understands that Dental Insurance claims may be billed by the provider, as a **courtesy**, if the provider participates in the patient's insurance plan. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

Unfortunately, this is no guarantee that the insurance company will pay for services. Our responsibility is to provide all accurate and pertinent information pertaining to the services provided to the insurance company. It is always patient's responsibility to provide us with accurate and current information regarding their effective insurance policy.

Based on services performed and treatment needed we can provide an estimate of the insurance coverage payment, however, this is only an estimate we cannot guarantee its accuracy. Many insurance policies have hidden clauses that allow for rejection or alteration of claim. If there is a problem with enrollment or coverage it is the patient that must approach the insurance company themselves. We will as a courtesy resubmit any previous claim, with the understanding that there are time limitations and many insurance companies will not consider a claim if too much time has passed from original date of service.

If for any reason the patient's insurance does not pay it is ultimately the undersigned that is responsible for all sums for services performed.

In the absence of prompt payment, the undersigned understands that medical, personal, and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the providers "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act."

APPOINTMENT NOTICES

Please note your appointment time carefully; this time has been reserved exclusively for you. Missed appointment times affect many people. The doctor and staff are prepared for your treatment and patients who have been waiting for treatment could have been seen at this time**. We reserve the right to charge for appointments cancelled or broken without 24 hours' notice. Charge is based on amount of time allowed for your procedure**. The minimum charge for a broken appointment is $50.

I, the undersigned, certify that ☐ I **am** an active-duty member of the U.S Armed Forces.
☐ I **am not** an active-duty member of the U.S Armed Forces.

Responsible Party Signature: ____________________________ Date: ____________________

I, ______________________________ have had an opportunity to read and consider the contents of this form. I understand that, by signing this form, with the knowledge that ever effort will be made to collect from the insurance company, I am ultimately responsible for the balance of the account.

Signature: ____________________________ Date: ____________________________

Printed Name: ____________________________