## Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

E-Mail Address:__ _____Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

**Have you ever had any of the following? Please check those that apply:**

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Joint replacement
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Currently **Pregnant** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _**Latex** Allergy
- ☐ Local Anesthetic
- ☐ Are you currently taking **ASPRIN**?
- ☐ Over the counter Meds

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

- Are you currently taking any medications, Including **ASPRIN** or **Blood thinner medications**? If so please list all of them, ☐ Yes ☐ No

_____

- Are you allergic to any medications? ☐ Yes ☐ NO

_____

To The best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

## Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐Relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

## Responsible Party Information

Name: _____

☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

## Dental Insurance Information

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

**Secondary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

## Consent for Services

As a condition of treatment by this office, I agree to allow all necessary dental radiographs and comprehensive exam by the doctor. I understand that if I do not agree with these terms, that the doctor can not make a diagnosis of my dental condition, oral health and treatment plan of necessary dental treatment needed to bring me to good oral health to standards and guidelines put forth by the Academy of General Dentistry and University of Maryland Dental School.

I have read the above conditions of treatment to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Dr. Farnoush Allen

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

**SECTION A: PATIENT/GUARDIAN GIVING CONSENT**

Name: _____

Address: _____

Telephone:_____

Social Security #: _____

**SECTION B: TO THE PATIENT/GUARDIAN — 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:

Dr. Farnoush Allen 7500 Greenway Center Drive Greenbelt, MD 20770 301.474.2505

**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. PLEASE ADVISE US IF YOU WANT A COPY.**

**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: _____

# Dr. Farnoush Allen

7500 Greenway Center Drive
Suite 120
Greenbelt, MD 20770

## Office Financial Policy, Revision Date: January 1, 2013

Thank you for choosing our office to serve your dental needs. We strive to provide the highest quality treatment at a reasonable cost to you. The following is a statement of our financial policy. Please read this document very carefully and sign below.

**********

**We have listed our payment options below for your convenience:**

Cash

VISA and MasterCard -minimum $10.00

Personal checks-(**patients of record only.)**

Care Credit-**Note:** Any interest free plan that has an unpaid balance at the end of the agreed upon term, will be charged a retroactive interest rate on the outstanding balance dating back to the original date of the loan.

**********

**We expect insured patients to read their policies carefully. It is very important that you are familiar with its benefits and limitations.** We will accept assignment of benefits provided the necessary documentation has been provided. **We do require that you pay your deductible and/or estimated co-pay at the time of service**. **If your insurance company has not paid your account in full within 45 days of treatment or denies your claim for ANY reason, you are responsible for the total balance.** For patients with dual insurance policies we will file your primary insurance claim we and will submit a claim for your secondary, but you are still responsible for any estimated co-pays from your insurance. If we have to resubmit your dental claim there will be a $25.00 service charge. For patients with secondary insurance, there will be a $15 administration fee.

**********

All prosthetic services **must be paid in full on or before completion**.
We reserve the right to charge any account balance due **over 60 days a 18% yearly finance charge** or a $5.00 repeat billing charge, whichever is greater. (Including payment plans.)
If your account is turned over for collection, you agree to pay any reasonable collection fees (25% is deemed reasonable) **If suit is filed, you agree to pay reasonable Attorneys fees (33.3% is deemed reasonable) court costs, and other expenses incurred as a result of said collection.** You agree that should suit be filed, venue (location of suit) shall be Prince Georges County, Maryland, venue in any other counties being waived hereby.
We consider the parent or guardian who brings the child to our office for treatment the responsible party for payment of the child's account. If someone else is legally responsible for the child's account, it remains the responsibility of the parent or guardian bringing the child in for treatment to seek reimbursement for payment made to our office. We will be happy to assist you by providing you with a copy of the charges and payments made at each visit.
**The office reserves the right to charge $30.00 per half hour for a broken appointment, maximum $60. To avoid a charge, 2-business days notice must be given. Each active patient will be allowed one broken appointment fee waiver a year.**
**All dental appointments <u>MUST BE CONFIRMED</u>. If an appointment is unconfirmed <u>24</u> hours prior to your appointment, your appointment time will be given to another patient.**
**A $15.00** fee will be assessed for the duplication of records/x-rays.
**A $37.00** fee will be added to your account for any checks returned to us by the bank.
**If your insurance pays less than estimated, you will be billed any balance due regardless of any treatment plan estimate presented.**

I have read and agree to the terms in this Office Financial Policy.

_____ _____
Signature of Patient/Parent/Guardian Date

_____
Printed Name of Patient