

# Welcome to Our Office

**Farah & Najafe Dental Associates**

Please complete all information requested.

## Patient Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
*First MI Last*

Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Pager/Cell (\_\_\_\_) \_\_\_\_\_

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Occupation \_\_\_\_\_

Full-time Student?  Yes  No School Attending \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced

In case of emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Are any of your family members patients of this practice?  Yes  No Name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## If the person responsible for the account is different than the patient, please complete:

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
*First MI Last*

Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Pager/Cell (\_\_\_\_) \_\_\_\_\_

Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Occupation \_\_\_\_\_

## Primary DENTAL insurance

Ins. Co. Name \_\_\_\_\_

Ins. Address \_\_\_\_\_

Ins. Phone (\_\_\_\_) \_\_\_\_\_

Group Plan # \_\_\_\_\_

Effective Date \_\_\_\_\_

Insured Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

## Secondary DENTAL insurance

Ins. Co. Name \_\_\_\_\_

Ins. Address \_\_\_\_\_

Ins. Phone (\_\_\_\_) \_\_\_\_\_

Group Plan # \_\_\_\_\_

Effective Date \_\_\_\_\_

Insured Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

## Patient Treatment Consent

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/Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Preferred method of Payment

- Co-payment in full by Cash/Check
- Co-payment in full by VISA/MC/Discover/Other Credit Source

# Medical History

Information that you feel insignificant could be directly related to your dental health. Answering 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 do not think it to be important.

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

<b>Do you have or have you ever been treated for:</b>	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
History of Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Gastric-Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions*	<input type="checkbox"/>	<input type="checkbox"/>	Adrenal/Pituitary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever*	<input type="checkbox"/>	<input type="checkbox"/>	X-ray or Cobalt Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint*	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis/Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis-Other	<input type="checkbox"/>	<input type="checkbox"/>
Do You Smoke	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
<b>*Do you need to take antibiotic premedication</b>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
<b>prior to dental treatment?</b>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Name of antibiotic normally prescribed _____			Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			Phen/Fen Regimen*	<input type="checkbox"/>	<input type="checkbox"/>

**Allergic reaction to (hives or swelling):**

Acrylic	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetic (Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Other (i.e., fruits) _____		

**If you are female are you:**

Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Nursing	<input type="checkbox"/>	<input type="checkbox"/>
Taking Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
Taking Hormone Medications	<input type="checkbox"/>	<input type="checkbox"/>

**Warning: Antibiotics reduce the effects of birth control pills**

OB/GYN name, address, phone \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any current health problems not listed above?  
 If yes, list \_\_\_\_\_

Are you currently being treated by a physician?  
 If yes list why \_\_\_\_\_

Date of last medical exam \_\_\_\_\_

Physician's name, address, and phone \_\_\_\_\_

Are you currently taking any medications, pills, or tonics? \_\_\_\_\_

List \_\_\_\_\_ For \_\_\_\_\_

List \_\_\_\_\_ For \_\_\_\_\_

List \_\_\_\_\_ For \_\_\_\_\_

## Dental History

Reason for today's visit \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Address or phone # \_\_\_\_\_

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 \_\_\_\_\_

(18 films or Panorex)

Date of last Prophy \_\_\_\_\_

Have you ever had any serious problems with past dental treatment?  Yes  No

If yes, explain \_\_\_\_\_

Do you have or have you ever been treated for:	Yes	No
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums when Brushing/Flossing	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Clicking or Popping Jaw	<input type="checkbox"/>	<input type="checkbox"/>
Grinding Teeth (Headaches)	<input type="checkbox"/>	<input type="checkbox"/>
Pain, Soreness of Facial Muscles	<input type="checkbox"/>	<input type="checkbox"/>
Food Collecting Between Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Loose Teeth or Broken Filings	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Hot	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Sweets	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Biting	<input type="checkbox"/>	<input type="checkbox"/>
Sores or Growths in Your Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dental implants?	<input type="checkbox"/>	<input type="checkbox"/>
Are you happy with your smile?	<input type="checkbox"/>	<input type="checkbox"/>

I have provided accurate information to the best of my knowledge related to my medical and dental health. I am responsible to inform the office of any changes in health history.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If minor, parent or guardian)

Dentist \_\_\_\_\_ Date \_\_\_\_\_

## Medical History Review and Update

Date \_\_\_\_\_  No Change  Change List Changes \_\_\_\_\_ New Medications \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Dentist/Hygienist Signature \_\_\_\_\_

## Medical History Review and Update

Date \_\_\_\_\_  No Change  Change List Changes \_\_\_\_\_ New Medications \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Dentist/Hygienist Signature \_\_\_\_\_

Use reverse side for future visits for medical history updates.

## Farah & Najafe Dental Associates

### CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name:

D.O.B:

Social Security #


TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**Purpose of Consent:** By either printing and signing this form, or submitting this form electronically, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care 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 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 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 our office at:

**Office Manager**  
**1740 Carl D. Silver Pkwy**  
**Fredericksburg, VA 22401**  
**Phone: 540-548-8878/ Fax: 540-548-8969**

**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 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.

Date signed: \_\_\_\_\_.

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

**Farah & Najafe Dental Associates  
1740 Carl D. Silver Pkwy.  
Fredericksburg, VA 22401  
Phone (540) 548-8878  
Fax (540) 548-8969**

## **FINANCIAL POLICY**

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.

**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 the 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 and 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.

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 every effort will be made to collect from the insurance company, I am ultimately responsible for the balance of the account.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

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**OFFICE POLICIES**

In consideration for the professional services rendered now and 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 \$35 bank processing charge in the addition to the amount of the returned check, in form of cash, money order or credit card.

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, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

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 provider's "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.** We understand that your time is important and we work hard to stay on schedule. Occasionally, emergency procedures cause us to be delayed and we apologize in advance.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party