FARWEST DENTAL GROUP, PC

HASSAN FAYOUMI, DDS / ANAS ALKWADRI, DDS

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Name: ____ Date: ______________________________

Address: ____

City: ______________________________ State: _________________________ Zip: _________________________

Home Phone: ______________________ Work Phone: ____________________ Cell Phone: ____________________

Gender (*Check One*): MALE ________ FEMALE _______ Date of Birth: _____________________________________

SSN: ___________________________________ Driver License Number: ____________________________________

Marital Status (*Check One*): SINGLE_________ MARRIED_________ DIVORCED__________ WIDOW____________

Email: ____ Occupation: ____________________________________

Whom may we thank for referring you to our office? ____

EMERGENCY CONTACT:

Name: ____ Relationship: ________________________________

Home Phone: ______________________________________ Cell Phone: ______________________________________

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insured: ____ Relationship: ______________________________

Insured's Date of Birth: ______________________________________ SSN: ______________________________________

Dental Insurance Company: ______________________________________ Insurance Phone: ______________________

Subscriber Number: ____ Group Number: ____________________________

Employer Name: _____________________________________ Insurance CO Address: ____________________________

Do you have a secondary dental coverage? (*Check one*) YES _____________ NO_______________

PATIENT DENTAL HISTORY:

Primary reason for this appointment *(Check one)*: Exam ___________ Emergency ____________ Consultation __________

Do you have a specific dental problem(*pain*)? ***Please Explain***: ____

____

Do you think you have active decay or gum disease? YES ______ NO ______

Do your gums ever bleed/hurt? YES _____ No _____ Do you want to keep your remaining teeth? YES _______ NO_______

Do you have clicking, popping, or discomfort? YES ______ NO _____

Does food get caught in your teeth? YES _____ NO _____; How often do you floss? _______ per day

How often do you brush? ______ per day; Are any of your teeth sensitive to HOT _______ COLD ______ SWEETS _______

Is there anything you would like to change about your smile? *If yes, explain:* ____

____

MEDICAL HISTORY:

Are you under the care of a physician? YES _____ NO _____ *If yes, explain*: ____

____

Have you ever been hospitalized or had a major operation? YES ____ NO ____ *If yes, explain:* __________________________

____

Do you bruise easily? YES _____ NO _____; Have you ever required a blood transfusion? YES _____ NO _____

Are you taking any medications, pills, or drugs? ***Please List:*** ____

Do you use tobacco? YES _____ NO _____ ***If yes, (check one)*** SMOKE _____ CHEW ____

Have you ever had any complications following dental treatment? ***If yes, please explain:*** _______________________________

____

Have you ever taken diet medication such as Redux (Fen-Phen)? YES _____ NO ______ ***If yes, when?*** ___________________

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Penicillin ___ Codeine ___ Tetracycline ___ Acrylic ___ Metal ___ Latex ___ Aspirin ___ Erythromycin ___ Iodine ___

Local Anesthetics ___ Other: ____

WOMEN ONLY: **(Are you): Pregnant ____ Nursing ____ Taking Oral Contraceptives ___**

If pregnant, when is your due date: ____________________________________

Do you have, or have had, any of the following:

___Angina   ___ Hemophilia   ___Alzheimer's   ___Kidney Problems   ___Excessive Thirst
___ Heart Attack   ___Anemia   ___Glaucoma   ___Renal Dialysis   ___ Epilepsy/Seizures
___ Heart Murmur   ___Scarlet Fever   ___Arthritis/Gout   ___Cancer   ___ Rheumatic Fever
___ Mitral Valve Prolapse   ___Asthma   ___Artificial Joint   ___Chemotherapy   ___Psychiatric Care
___ Congenital Heart Disorder   ___Easily Winded   ___Swelling of The Limbs   ___Radiation treatments   ___Hypoglycemia
___ Pace Maker   ___Emphysema   ___Cortisone Medication   ___Leukemia   ___Fainting Spells/Dizziness
___ Chest Pains   ___Lung Disease   ___Ulcers   ___Liver Disease   ___Bruise Easily
___ Irregular Heartbeat   ___Tuberculosis   ___Frequent Diarrhea   ___Hepatitis A, B, or C   ___ Shingles
___ Artificial Heart Valve   ___Hay Fever   ___Gastric Reflux Disease   ___Drug Addiction   ___Diabetes
___ High Blood Pressure   ___Sinus Trouble   ___Recent Weight Loss   ___AIDS/HIV   ___Stroke
___ Low Blood Pressure   ___Frequent Headaches   ___Eating Disorder   ___Venereal Disease   ___ Excessive Bleeding

Have you had any other illness not listed above? ***If yes, please list***: ____

To the best of my knowledge, I have accurately answered the questions on this form. I understand providing incorrect or incomplete information can be dangerous to my/patient's health. It is my responsibility to inform Farwest Dental Group of any changes in my medical status in a timely manner. I authorize my insurance benefits to be paid directly to Farwest Dental Group. I am financially responsible for any balance.

_____________________________________   ____   _____/_____/_____

Patient/ Guardian Signature   ***Doctors Signature***   ***Date***

________________________________   _____/_____/_____   ________________________________   _____/_____/_____

1st Recall Visit – Patient Signature   ***Date***   ***2nd Recall Visit – Patient Signature***   ***Date***

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Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, ________________________________, acknowledge I have received from Farwest Dental Group a copy of the Dental Materials Fact Sheet dated October 17, 2001.

____ ______________________________

Patient Signature/Legal Guardian ***Date***

The introductory prevision of the Dental Materials Fact Sheet is reprinted below for reference purposes only.

The following document is the Dental Board of California's Dental Materials Fact Sheet. The department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet; and its linkage to the DCA web site does not constitute an endorsement of the content of this document.

The Dental Board of California - Dental Materials Fact Sheet

Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." A "Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993. The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene, home care, diet and chewing habits.

-OFFICE COPY-

FARWEST DENTAL GROUP, PC

HASSAN FAYOUMI, DDS / ANAS ALKWADRI, DDS

Private Patient Deposit Policy

Effective Date: June 1, 2010

To reserve a new dental appointment patient is required to leave **$50 deposit** that will be applied to schedule treatment. Due to large number of no-shows and last-minute cancellations we are being forced to require this deposit to save you the spot on our busy schedule. We try our best to accommodate your personal schedule, therefore we only ask that you respect ours. If the patient doesn't show to his/hers scheduled appointment without cancelling **24 hours prior,** patient will lose **$50** deposit. This $50 deposit will be automatically applied towards our **NO-SHOW** fee**.**

Thank you for your consideration in this matter.
I have read the above policy and agree to abide by it.

_______________________________ _____________________________________

Date ***Patient Signature/Legal Guardian***

24 HOUR CANCELATION POLICY

Our office strives to reserve dental appointments that accommodate your personal schedule as much as possible. Should you be unable to keep your reserved appointment, we reserve the right to request sufficient notice (24 hours), so that we may appoint someone else who is waiting for our care. Cancellations with less than **24 hours**' notice are considered **NO-SHOWS**. Depending on the nature of the cancellations and treatment plan in place we reserve the right to charge a **$50 cancellation fee** that must be paid before further appointments are made in this office. Thank you for your consideration in this manner.

I have read the above policy and agree to abide by it.

_________________________________ ____

Date ***Signature of Client (parent or guardian)***

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FINANCIAL AND INSURANCE POLICIES

The dental providers and staff of Farwest Dental Group strive to offer comprehensive, quality care to all of our patients. We feel that it is appropriate to inform our patients in advance of the office, financial and insurance policies required at Farwest Dental that may ultimately affect their care. Please read the following policies carefully and initial after each. Please sign and date your understanding at the end of this form. If you are a patient under the age of 18, your responsible party must also read and sign this form.

Private/Cash Accounts
I am responsible, at the time of service, for all expenses incurred during my office visit. Farwest Dental Group accept cash, checks, money orders, MasterCard, Visa, Discover and American Express credit cards. We also accept Care Credit as a payment plan.
Initials _______

Insurance Co-pays
My co-pay is due at the time of my dental procedure. Also, insurance deductible is due at the time of my appointment. We accept cash, checks, money orders, Master Card, Visa, Discover and American Express credit cards. We also accept Care Credit as a payment plan. Initials _______

Non-Covered Services
Non-Covered surfaces will need to be paid at the time of service. Possible examples of non-covered services include teeth whitening, irrigation or any procedure not covered under your particular insurance contract. I understand that my insurance company may not cover composite (white) fillings. If my insurance company only covers Mercury fillings, I understand that I am responsible for the difference in cost.
Initials _______

Returned Check Fees
I understand that if Farwest Dental receives a returned check written by me or on my behalf, I will be charged a returned check fee of $30.00 and will be required to pay cash or use a credit card for account balance that is owed. Failure to repay the returned check and the returned check fee will result in collection proceedings and dismissal as a patient from Farwest Dental Group.
Initials _______

Collection Process
Any balances determined as patient responsibility that remain unpaid after 90 days will be subject to an in-house review. You should be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. By law your insurance company is required to pay each claim within 30 days of receipt. We file claims in a manner such that your insurance company will receive claims within days of treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 60 days, a finance charge may be added to your account each month until paid. If you have not made payment arrangements with our office with 90 days of services being provided, your account may be frozen and referred for collection. Once referred for collection, further services will not be provided until the outstanding balance is paid. In the event payment cannot be made in full within the above referenced time frames, please call the office to discuss alternative payment plans. We will make every attempt to accommodate your situation.
Initials_______

Missed Appointments
I understand that Farwest Dental Group will, but is not required to, call my home to confirm my upcoming appointment date and time. I understand that this is a courtesy and that I am ultimately responsible to keep my office appointment. I understand that the office will charge a **$50 missed appointment fee** for appointments missed and

not changed or cancelled within **24 hours prior** to my scheduled appointment.
Initials _______

Dental Records Release
Farwest Dental will release dental records within a valid **HIPPA** compliant authorization or a court-ordered subpoena is received. If for any reason you decide to leave our practice, we understand you have the right to request copies of your dental records/x-rays. There will be a **$50** fee to duplicate x-rays taken by us. We are licensed by the California Board of Radiology to take X-rays, and are required by law to retain originals on file.
Initials _______

Discharge of a Patient
I understand that Farwest Dental has the right to discharge any patient from this practice at any time for various reasons, including, but not limited to failure to abide by Farwest Dental financial policies, noncompliance of recommended treatment, drug-seeking activity, and any abuse of Farwest Dental providers and staff.
Initials _______

Farwest Dental Group Insurance Policy
Farwest Dental Group participates with many insurance carriers and it is my responsibility to choose a dental provider that participates with my insurance plan. I am also responsible for informing Farwest Dental Group if my insurance changes. I am ultimately responsible for all charges incurred at Farwest Dental Group. If I have any questions or concerns regarding the benefits of my policy, I should contact my insurance company directly. I hereby authorize Farwest Dental to submit a claim and to furnish complete information to my insurance carrier to issue payment on my behalf to Farwest Dental Group.
Initials _______

I HAVE READ AND UNDERSTAND THE OFFICE, INSURANCE AND FINANCIAL POLICIES OF FARWEST DENTAL GROUP.

_______________________________________ _______________________________
Print Name ***Date***

_______________________________________ _______________________________
Signature ***Date***

_______________________________________ _______________________________
Doctor's Signature ***Date***