SHUAYB DENTAL

Name_____ Nickname_____
Last *First* *Middle*

Address_____ Soc Sec #_____

City_____ State_____ Zip_____ Home #_____

Birth Date_____ Sex ☐M ☐F Marital Status _____ Cell #_____

Email_____ Driver's License #_____

Employer/Occupation_____ Work #_____

Who may we thank for referring you _____

Emergency Contact_____ Relation to Patient_____
Home #_____ Work #_____ Cell #_____

Responsible Party (for minor patient)

Name_____ Soc Sec #_____
Last *First* *Middle*

Address_____ Phone #_____

Relation to Patient_____ Driver's License #_____

Employer/Occupation_____ Work #_____

Insurance Information

Name of Subscriber_____
Last *First* *Middle*

Relation to Patient_____ Birth Date_____ Soc Sec #_____

Address (if different from patient) _____

Employer_____ Work #_____

Insurance Co_____ Group #_____

Dental History

Reason for today's visit_____

Interested in Whiter Brighter Smile? □Yes □No □Would like more information

If you could change your smile, what would you change? _____

_____

Date of last dental x-rays_____

Check if any of the following apply:

□ Aids/HIV Positive
□ Anemia/Sickle Cell Disease
□Arthritis/Rheumatism
□Artificial Heart Valve
□Artificial Joints
□Asthma
□Bad Breath
□Bleeding Gums
□Blood Thinners
□Blood Transfusion
□ Other_____

□ Cancer
□ Chemical Dependency
□ Chemotherapy/Radiation
□ Clicking for Popping Jaw
□ COPD
□ Diabetes
□ Emphysema
□ Epilepsy/Seizures
□ Fainting or Dizzy Spells
□ Glaucoma
□ Other_____

□ Grinding Teeth
□ Hay Fever
□ Heart Attack
□ Heart Murmur
□ Heart Pacemaker
□ Hemophilia
□ Hepatitis
□ Herpes
□ High Blood Pressure
□ Kidney Disease
□ Other_____

□ Latex Allergy
□ Liver Disease
□ Periodontal Treatment
□ Psychiatric Care
□ Rheumatic/Scarlet Fever
□ Sensitivity
□ Stroke
□ Thyroid Disease
□ Tobacco Habit
□ Tuberculosis
□ Ulcers

List all medication(s) you are currently taking:

_____
_____
_____
_____

List any drug allergies:

_____
_____
_____
_____

- I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance.
- I assign dental benefit payments to be paid directly to the Doctor from my insurance company.
- I give permission for my dentist and his/her clinical team to take any necessary diagnostic films, photos or study models to properly enable complete diagnosis and treatment.

Authorization & Release

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that it is my responsibility to inform the office of any changes to my medical status. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all my insurance submissions. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

Signature_____ Date _____

Financial Policy

Welcome to our dental practice! We are glad to have you as our patient and look forward to the opportunity to meet your dental health needs.
Our mission is to deliver the finest, most cost effective treatment available today. Please review and initial the following so that we can achieve our mission together.

_____**Payment**

Payment for services is due at the time services are rendered, unless specific arrangements are made in advance. Payment may be made with cash, check, Visa, MasterCard, Discover and AMEX. We offer payment plans thru Care Credit.

_____**Insurance**

As a courtesy to those patients who are covered by insurance, we will bill your insurance for you and accept the assignment of benefits. However, we want to emphasize that our relationship is with you, not your insurance company. All charges are your responsibility from the date services are rendered and your patient co-payment is due at the time of service. We will **estimate** your co-payment to the best of our ability but the **estimate** is simply a guideline until the final insurance payment is received. If there is a remaining balance following insurance payment, this balance must be paid within 30 days of being billed by this office. We strongly advise you to become familiar with your specific insurance plan and your covered benefits as every insurance plan is different and some routine procedure(s) may not be covered or may be limited to a certain frequency.

_____**Billing Charges**

Account balances over 90 days may be subject to collection or legal action unless prior arrangements have been made for the balance.

_____**Returned Checks**

All returned checks are subject to a service charge.

HIPPA Consent Form

OUR LEGAL DUTY. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it. The Notice of Privacy Practices is available upon request and a copy this Notice is located in the waiting room.

Patient Signature_____ Date_____

Authorized Signature if Patient is a Minor_____

Appointment and Cancellation Policy

Patient Name (Print) **Date:**

Our goal at Shuayb Dental is to provide quality dental care in a timely manner. As a growing dental practice, we have a high number of individuals seeking our treatment. This policy enables us to better utilize available appointments for our patients in need of dental care.

PLEASE INITIAL ON EACH LINE

____**1.** **Cancellation of an Appointment:** Shuayb Dental will make every effort to accommodate your scheduling needs. In order to be respectful of the dental needs of others, please be courteous and call if you are unable to attend an appointment as we have staffed to accommodate your appointment needs.

*If it is necessary to cancel or reschedule your appointment, **we require that you call 24 hours in advance**. Appointments are in high demand and your early cancellation notice will be appreciated and allow another person the possibility to have access to timely dental care. This is how we can best serve the needs of our patients here at Shuayb Dental.

____2. **How to Cancel your Appointment:** To cancel appointments, please call (352)794-6354. If you do not reach the scheduling coordinator you may leave a detailed message on the voice mail. You may also cancel using our email at shuaybdentalcrystalriver@gmail.com

____3. **Late Cancellations**: Late cancellations without a 24 hour notice will be considered as a **"NO-SHOW"**.

____4. **No-Show Policy:** A **"No-Show"** is someone who missed an appointment without a 24 hour advance notice. No-Shows inconvenience those individuals who need access to dental care in a timely manner.

____**5.** Failure to cancel 24 hours before your appointment **will result in a 30% charge of your total treatment scheduled or $40.00 No-Show fee (whichever is greater).** The fee will not be waived until your appointment and treatment is completed. Shuayb Dental may require a 100% pre-payment or a deposit in order to reserve any further appointments. The pre-payment and or deposit will be applied to your next scheduled appointment after completion of treatment.

____**6.** After two **"No-Shows" or "Late Cancellations"** you risk being dismissed from practice.