PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form.

Name: (Last)_____(First)_____(Middle)_____

SS#: _____-_____-_____ Date of birth: _____ Age:_____ □ M □ F

Parent/Guardian's Name: _____

Mailing Address: _____ Apt #_____

City: _____ State:_____ Zip Code:_____

Home Phone: _____ Cell #: _____

Employer: _____ Occupation: _____

Work Phone: _____

Spouse' Name (or Nearest Relative): _____

Emergency Contact: _____ Relationship: _____ Ph#_____

Dental Insurance company : _____

Policy or group Number : _____

If you are Covered by Spouse's Insurance, please fill the following information.

Spouse Dental insurance company_____ Group Number_____

Spouse's Birthday: ___/___/___ Spouse's SSC #: _____-_____-_____

Whom may we thank for referring you to our office?

- □ Insurance: _____
- □ Web search:_____
- □ Friend (name):_____
- □ Other (please specify):_____

Email address: _____

PATIENT HEALTH QUESTIONNAIRE

Please answer all questions by circling either YES or NO, and fill all the blank spaces when indicated. Answers to the following questions are for our records only and are confidential.

1. My last medical physical examination was on (approximate):_____

2. My personal physician's:
   - Name:_____
   - Address:_____
   - Phone Number:_____

3. □ Y □ N Are you ***NOW*** under care of a Physician?
   If yes, what is the condition being treated? _____

4. □ Y □ N Has your physician instructed you that you need prophylactic antibiotic premedication due to an existing medical condition?

5. □ Y □ N Have you had any serious illness or operation?
   If yes, what was the illness or operation?_____

6. □ Y □ N Have you been hospitalized within the past 5 years?
   If yes, what was the problem _____

7. Do you have or have you had any of the following diseases or problems:
   □Y □ N Any Heart Problem?
   If yes, please specify in **DETAILS:** _____
   □ Y □ N Artificial joint/joint replacement
   □ Y □ N Stroke
   □ Y □ N Radiotherapy or Chemotherapy, if yes, when and why? _____

8. Do you have any of the following diseases or problems:

□ Y □ N Sinus trouble	□Y □ N Sever Gag Reflux
□ Y □ N Fainting spells or seizures	□ Y □ N Hives or skin rash
□ Y □ N Diabetes	□ Y □ N Hepatitis jaundice/ liver disease
□ Y □ N Arthritis	□ Y □ N Do you smoke or use tobacco
□ Y □ N Mouth ulcers	□ Y □ N Kidney trouble
□ Y □ N Tuberculosis (TB)	□ Y □ N Persistent cough or cough up blood
□ Y □ N High blood pressure	□ Y □ N Low blood pressure
□ Y □ N Epilepsy	□ Y □ N AIDS/other immunosuppressive disorders
□ Y □ N Stomach ulcer	□ Y □ N Drug or alcohol abuse

□ Y □ N Do you have any blood disorder? (Anemia, sickle cell anemia, etc.)
□ Y □ N Abnormal bleeding associated with previous extractions, surgery, trauma?
□ Y □ N Are you taking any drug or medicine?
If yes, please list _____

- Are you taking any of the following?
  □ Y □ N Aspirin □ Y □ N Cortisone(steroids) □ Y □ N Blood thinners
  □ Y □ N Coumadin □ Y □ N Fosamax or Actonel or Boniva

- Are you allergic to any of the following?
  □ Y □ N Penicillin or other antibiotics □ Y □ N Latex
  □ Y □ N Local aesthetics □ Y □ N Codeine
  Other (please specify)_____

9. □ Y □ N Have you had any serious trouble associated with any previous dental treatment?
If yes, please explain: _____
_____

10. □ Y □ N Do you have any disease, condition, or problem not listed above that you think we should know about? If yes, please explain:
_____
_____

- Women: □ Y □ N Are you pregnant? If yes, how many weeks? _____
  □ Y □ N Are you nursing?
  □ Y □ N Are you taking contraceptive pills?

I certify that I have read and understood the above. Knowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature_____ Date_____

Radiance Dentistry
WE LOVE TO SEE YOU SMILE
972.258.1702
972.258.1703

OFFICE FINANCIAL POLICY

1. We accept most PPO and indemnity dental insurance plans, but not DMO's. For most of these we'll only require you to pay your estimated portion of the charges. However, the insurance company may pay less than estimated, or nothing at all – **by signing this form you agree that you are financially responsible for the entire amount of the charges incurred**.
2. For patients with insurance, we do file your claims as a courtesy, and we will collect your *estimated* portion at time of service. If your insurance has not made a payment within 30 days you will be billed for the balance.
3. Payment of all charges is due in full for treatment to be rendered, unless alternative financing has been approved and funded.
4. If You refuse to provide your SSN, you agree to pay IN FULL with credit card or cash, regardless of your insurance status.

Appointment Rescheduling or Cancellations Policy: Please give us at least 24 hours' notice for cancelling or rescheduling your appointment, or noon Friday for Monday appointments. This courtesy makes it possible to give your reserved room to another patient who would like it. **A charge for not showing up for scheduled appointments for the lost production time up to $200. Repeated cancellations or missed appointments will result in loss of future appointment privileges.**

By signing this you are acknowledging that you have read, understood, and accepted our policies, and that we've provided a copy of the "Health Insurance Portability & Accountability Act of 1996 (HIPAA)" for you to read.

Payment Options

1. Credit/Debit Cards – We accept Visa, MasterCard, Discover, and American Express.
2. Third Party Financing - For cases over $1,000 we have arranged for third party financing with repayment schedules up to 60 months, reasonable interest rates, and no pre-payment penalties. Application can be made over the phone from our office, with most approvals within 15 minutes.

The covered procedures and amount of payment for each procedure you have if you have dental insurance is an agreement between you, your insurance company, and/or your employer. By signing below, you understand you are responsible for all fees, regardless of expected insurance coverage, including missed appointment fees, and any legal or other costs incurred in the collection of the account, if it becomes delinquent. You agree it is your responsibility to know your insurance benefits, and that while we may attempt to ascertain information on same from your insurance carrier for you, we cannot be liable for any incorrect information we obtain or assume on your behalf. You agree to assign all insurance benefits to Radiance Dentistry. You authorize us to check credit history and scores while verifying potential credit worthiness if we feel there is a possibility you may require financing in full or in part of any treatment. You also agree that your consent to any treatment plan (i.e., sitting in the chair for treatment) releases Mounir Iskandar, DDS, P.L.L.C. and its employees from any and all claims arising from treatment.

Name (Print): _____

Name (Signature): _____

Date: _____

RELEASE FORM (APPROVED HIPPA DISCLOSURES)

- I certify that the provided information is complete and accurate.
- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care, including x-rays.
- I authorize release of any information concerning my (or my child's) health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize photographs to be taken, intraorally and/or extraorally. I authorize use of these photographs by the dentist within the practice, as well as externally, for educational purposes and/or case presentations.

IMPORTANT:

- My preferred method of communication regarding my appointments or my Dental/Medical condition is:
  □ Home Phone □ Work Phone □ Cell Phone □ E-mail
  If the selected method is by phone please check the appropriate box below:
  □ leave a message with detailed information
  □ leave a message with call-back number only

- Keeping our Patient's information private is important to us and by default we only disclose information related to the patient's billing account and Dental/Medical conditions to the Patient only or legal Guardian. Do you authorize any family member/spouse to discuss or inquire any information about your treatment plan, dental condition, insurance/financial or any other issues related to your treatment in our office? □ Y □N

  If yes, please mention,
  1- Name _____
  2- Contact number_____
  3- Relationship_____

- I hereby authorize payment of insurance benefits otherwise payable to me directly to Mounir Iskandar DDS, P.L.L.C. DBA radiance dentistry. If the insurance company mistakenly reimburses me, I am responsible for signing any reimbursement over to Mounir Iskandar DDS, P.L.L.C

- In the event of any disagreement regarding quality of services provided that cannot be resolved, I agree to submit those concerns to the peer review committee of the Dallas county dental society and be bound by their recommendations for resolution.

- By signing this you are acknowledging that you have read, understood, and accepted our policies, and that we've provided a copy of the "Health Insurance Portability & Accountability Act of 2010 (HIPAA)" for you to read.

- I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

PATIENT/PARENT (GUARDIAN) _____ **DATE:** _____

ACCOUNT GUARANTOR (IF DIFFERENT) _____ **DATE:** _____