Health Information

ALL INFORMATION IS CONFIDENTIAL

Patient's Name: _____Date of Birth: _____Last Physical Date: _____

Physician's Name & Phone #: _____Reason for today's visit? _____

Have you ever been hospitalized? (circle) **Yes No**

Height: _____Weight: _____

Date of last dental visit:_____Date of last dental x-rays:_____Date of last cleaning:_____

Do you have a history of periodontal (gum) disease? (circle) **Yes No**

Have you had a dental injection before? (circle) **Yes No**

Are you interested in tooth whitening? (circle) **Yes No**

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) **Yes No**

Are you taking or have taken Oral Bisphosphonates?(e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, (e.g., ZOMETA, AREDIA) (circle) **Yes No** Taken for how long? _____

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes No**

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes No**

List any medications you are allergic to:

1. _____ 2. _____ 3. _____ 4. _____

List any medications you are taking including non-prescription drugs and herbals/vitamins:

1. _____ 2. _____ 3. _____ 4. _____

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Alcoholism		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth sores/growths		
Diabetes			Teeth Grinding/Clenching			Pace Maker/Heart Surgery			Aspirin/Anticoagulant Therapy		
Venereal Disease			Arthritis			Pain in your jaw (TMJ)			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Any type of Implant		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (Type:)		
Any type of Transplant			Heart Problem ( )			Excessive Bleeding			Any Artificial Hip, Knee or other Joint		
Drug Addiction			Dialysis			Stroke			Other Disease or Illness:		
Hepatitis (Type:)			Chemotherapy			Lung Disease					
Liver Disease			Radiation Treatment			Breathing Problems					
Kidney Disease			Use of Tobacco Products			Tuberculosis (TB)					

Women patients only:	Y	N		Y	N
Is there a possibility of pregnancy?			Are you nursing?		
Estimated Delivery Date: / /			Are you taking any birth control prescriptions?		

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient's Signature_____Date_____Dr's. Signature/Medical History Review_____Date_____

Patient Information

Please Print

Circle One: Dr/Mr/Mrs/Ms/Miss
First: _____Middle: _____ Last: _____Jr/Sr: _____
Street: _____ City: _____ State:_____ Zip:_____
Home Phone: _____Work Phone: _____
Cell Phone: _____
Email Address: _____ May we contact you by email? (circle) **Yes No** Patient
Social Security Number:_____ Patient Date of Birth: _____Sex: (circle) **M F** Emergency
Contact:_____ Phone: _____
Preferred Pharmacy_____
How did you hear about us?
☐Newspaper ☐Radio ☐TV ☐Internet ☐Referral ☐Other: _____

Insurance Information

Do you have Dental Insurance? (circle) **Yes No** Do you have Secondary Dental Insurance? (circle) **Yes No**

Primary Insured		**Secondary Insured**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	Self Spouse Child Other	Relationship to Subscriber	Self Spouse Child Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please present your insurance card to our patient services representative to be photocopied			

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:
Name of Recipient: _____
Relationship to the Patient: _____

I give authorization to disclose the following information:

- ☐ All treatment information
- ☐ Information specifically related to these treatment dates

Starting Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying Nordahl Dental at any time.

Signature of Patient (or Patient Representative) _____ Date: _____
Printed Name of Patient (or Patient Representative) _____

Financial Policies

Our mission is to deliver the finest, most cost-effective health care treatment available today. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the investment in today's and future treatment.

Payment is due at the time services are rendered. For your convenience we accept cash, personal check, Visa, MasterCard & Discover. We also offer convenient payment options through CareCredit.
Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer.

As a courtesy we will be glad to file your claim for you provided we have complete and accurate insurance information. You will be expected to pay for services rendered if the office is unable to verify your insurance information prior to treatment. If payment for services already rendered has not been paid within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible. Should additional means of collection become necessary, all costs of collection, including attorney fees, court costs and collection agency fees (35% standard collection/ 50% legal collection) will be added to your existing balance. Your cooperation with this policy will assure equitable treatment of insured and non-insured patients.

We reserve the right to charge and collect fees for broken appointments. Appointments are reserved exclusively for you. We consider an appointment confirmed once the appointment is scheduled. A minimum charge of $50 per hour may be posted to your account if an appointment is cancelled without a 48 hour advance notice. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

Any accounts overdue for patient payment in excess of 45 days are subject to an interest fee of 18% per annum. A returned check fee of $25 will be added to your account balance for any checks returned to us as non-sufficient funds (NSF).

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment. I, the undersigned, authorize payment of the dental benefits otherwise payable to me, directly to **Rima C. Shahhal, D.D.S.**

Signature_____Date_____

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above)

Photography

I authorize Dr. Sami I. Shahhal & Dr. Rima C. Shahhal to take photographs of my teeth. I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, professional publications, website & media. I understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. **NO FULL FACE PHOTOS WILL BE USED WITHOUT YOUR EXPRESSED WRITEEN CONSENT**. I do not expect compensation, financial or otherwise, for the use of these photographs. By signing below, I acknowledge that I agree to abide by such policies.

Signature_____Date_____

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above)

HIPPA CONSENT

Name:_____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996[HIPPA}. I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

*Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
* Obtain payment from third party payers (e.g. my insurance company).
*The day-to-day healthcare operations of the practice.

I also have been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that I reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and restricted to carry out treatment, payment, and health care operations; but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure prior to the date I revoke this consent is not affected.

Print Patient Name_____

Signature_____

Relationship to Patient_____

Date _____/_____/_____

Person(s) to Be Added To HIPPA_____

_____