A GREAT Smile DENTAL
FAMILY & COSMETIC DENTISTRY

Dr. Ben Yaghmai, DDS - Dr. E Orlando Morantes, DDS - A Great Smile Dental
3412 N Buffalo Drive
Las Vegas, NV 89129
Phone: (702) 804-5154
Fax: (702) 804-5176

Chart#_____

WELCOME TO OUR PRACTICE

On behalf of entire team at A Great Smile Dental, let me welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long-lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer.

In order to better serve you, we are enclosing in the Welcome Packet several important documents that will assist us to making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Personal Information Sheet and Medical and Dental History questionnaire that should be filled our prior to your first appointment with us.

Be sure to visit our website at www.agreatsmiledental.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Dr. Ben Yaghmai, DDS, Dr. E. Orlando Morantes, DDS

and the AGSD Team

3412 N Buffalo Drive Las Vegas, NV 89129 (702)804-5154

How did you find our office?

☐ Referred by a friend/relative ☐ Insurance ☐ Facebook ☐ Yelp ☐ Google Search

☐ Living in the Neighborhood ☐ Other (please explain)

Who should we thank for referring you to our practice?

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• PATIENT ACKNOWLEDGEMENT

Initial_____Our practice is committed to providing the best treatment for our patients. We encourage you to notify us of any changes to your health status.

Initial_____ No minor children (under the age 18 years old) will be treated without a parent present during treatment. A notarized letter giving a relative permission to bring a minor is acceptable.

Initial_____As a condition of treatment by this office, I understand financial arrangements must be made in advance.

Initial_____We accept Cash, Visa, MasterCard, Discover and American Express.

Initial_____I hereby authorize and request my insurance company to pay directly to A Great Smile Dental that amount due on my claim for services rendered to my dependents or me.

Initial_____As a courtesy to you, we will verify your insurance coverage. It is your responsibility to notify us immediately if your insurance company or/coverage changes.

Initial_____The deductible and co-payments are due at the time of the treatment and not all services recommended are covered benefit by your insurance company.

Initial_____I understand that dental services provided are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand this office help to prepare my insurance claim to assist in making collections from insurance and will credit such collection to my account. However this office cannot render services on the assumption that charges will be paid by your insurance company.

Initial_____Your insurance policy is the contract between you, your employer and the insurance company. We are not a party to that contract. If by any reason my insurance company does not cover for a service you are fully responsible for the charged amount.

Initial_____We reserve the right to charge $50 per hour for appointments cancelled or broken without 24 business hours advance notice.

Initial_____Returned checks are subject to $25 fee, due immediately, and check writing privilege will be revoked.

Initial_____Any balance past due over 90 days is subject to be sent to collection agency, I will be responsible for any fees associated to this matter. I also understand that in order to collect my debt, my credit history may be check through the use of my social security number or any other information I have given you.

Initial_____I grant my permission to you and your agents, to telephone me at home or at my work to discuss matters related to this form.

Initial_____As a courtesy we bill secondary insurance, but expect all co-payments at the time of service. We will refund or credit your account when all insurance payments have been received.

I have read the above conditions and agree to their content.

Signature_____ **Date**_____

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• GETTING TO KNOW YOU

Patient Information

Patient Name	Social Security Number	Birthdate
Home Address	City, State, Zip	Home Phone
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	Sex Male ☐ Female ☐	Mobile Phone
E-Mail Address	Best phone number to reach you ☐ Home ☐ Mobile	

Primary Insurance Company _____ Group _____ Member ID _____

Secondary Insurance Company _____ Group _____ Member ID _____

Responsible Party

Primary Insurance Subscriber Name	Social Security Number	Birthdate
Home Address	City, State, Zip	Home Phone
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	Relationship to Patient	Mobile Phone
E-Mail Address	Best phone number to reach party ☐ Home ☐ Mobile	
Secondary Insurance Subscriber Name	Social Security Number	Birthdate
Home Address	City, State, Zip	Home Phone
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	Relationship to Patient	Mobile Phone
E-Mail Address	Best phone number to reach party ☐ Home ☐ Mobile	

Patient's Dental History

(please select any that apply to you)

1. Y☐ N☐ I clench or grind my teeth during the day or while sleeping.
2. Y☐ N☐ My gums bleed while brushing or flossing.
3. Y☐ N☐ I avoid brushing part of my mouth due to pain.
4. Y☐ N☐ My gums feel tender or swollen.
5. Y☐ N☐ I have problems eating.
6. Y☐ N☐ I have had orthodontics.
7. Y☐ N☐ I have had facial or jaw injury.
8. Y☐ N☐ I have clicking or popping of my jaw.
9. Y☐ N☐ I have facial muscle pain.
10. Y☐ N☐ I have jaw joint pain.
11. Y☐ N☐ I chew on ice or hard foods.
12. Y☐ N☐ I eat sour foods regularly.
13. Y☐ N☐ I let candies melt in my mouth.
14. Y☐ N☐ I enjoy different forms of sweets on a daily basis? (eg: soda, energy drinks, chocolate, etc?)

Smile Questionnaire

1. Y☐ N☐ Are you happy with your smile?
2. Y☐ N☐ Is there any part of your smile you would like to change? (Explain)
3. Y☐ N☐ Are you satisfied with the color of your teeth?
4. Y☐ N☐ Do you have gaps in your teeth that you are unhappy with?
5. Y☐ N☐ Are you unhappy with the appearance of any fillings or other dental work, if so where?

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• PATIENT'S HEALTH HISTORY

I consider my health to be *(please check one):* Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you have or have you ever had any of the following? Please check Y for yes or N for no.

1. Y N Osteoporsis
2. Y N Heart Disease
3. Y N Heart Murmur/Mitral Valve Prolapse
4. Y N Congenital Heart Disease
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Prosthetic Heart Valve
8. Y N Pacemaker
9. Y N History of Bacterial Endocarditis
10. Y N Tuberculosis or Lung Disease
11. Y N Stroke/Ministroke
12. Y N Anemia
13. Y N Prolonged Bleeding Disorder/Bruise Easily/Hemophilia
14. Y N Asthma/Breathing Problem
15. Y N Hay Fever
16. Y N Sinus Trouble
17. Y N Epilepsy/Seizures
18. Y N Ulcers
19. Y N Implants/Artificial Joints: Hip-Knee _____ Other _____
20. Y N I smoke or use chewing tobacco. If yes, how much per day? _____
21. Y N I usually take an antibiotic prior to dental treatment.
22. Y N Have you ever taken Fen-Phen or Redux?
23. Y N Liver Disease/Jaundice
24. Y N Acid Reflux/Heartburn
25. Y N Hepatitis Type _____
26. Y N Diabetes/Excessive Urination/Thirst
27. Y N Herpes
28. Y N Colitis/IBS
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Diseases/HIV Positive
31. Y N Kidney Disease
32. Y N Tumor or Malignancy/Cancer
33. Y N Chemotherapy
34. Y N I have had major surgery. Year(s) _____ Type of operation(s) _____
35. Y N Thyroid Problem

36. Y N Radiation/Therapy
37. Y N History of Drug Addiction
38. Y N AIDS
39. Y N Immune Suppressed Disorder
40. Y N Auto Immune Disease
41. Y N Hearing Loss
42. Y N Fainting Spells
43. Y N Glaucoma
44. Y N History of Emotional or Nervous Disorders
45. Y N Shunt in the body
46. Y N Cold Sores/Fever Blisters/Herpes
47. Y N Frequent Headaches

WOMEN:

48. Y N Are you taking birth control medication?
49. Y N Are you or could you be pregnant or nursing?

Are you allergic to any of the following?

50. Y N Aspirin
51. Y N Ibuprofin
52. Y N Sulfa Drugs/Sulfites/Sulfides
53. Y N Penicillin
54. Y N Codeine
55. Y N Latex, Metals, Plastics
56. Y N Local Anesthetics (Novocaine)
57. Y N Other Medications. If yes, which ones?

_____
_____
_____
_____

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• PATIENT'S HEALTH HISTORY (cont.)

58. [Y] [N] Has anyone told you that you snore?
59. [Y] [N] Do you suffer from snoring?
60. [Y] [N] Do you wake up choking, gasping, or experiencing shortness of breath?
61. [Y] [N] Do you feel tired or fatigued during the day?

62. [Y] [N] Do you have any other medical problems or medical history NOT listed on this form?

_____
_____
_____
_____
_____

Please list all medications you are currently taking:

Medicine _____ Condition_____ Medicine _____ Condition_____
Medicine _____ Condition_____ Medicine _____ Condition_____
Medicine _____ Condition_____ Medicine _____ Condition_____
Medicine _____ Condition_____ Medicine _____ Condition_____
Medicine _____ Condition_____ Medicine _____ Condition_____
Medicine _____ Condition_____ Medicine _____ Condition_____

Physician's Name _____Phone _____
Address _____ Fax _____

I have accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in my (or the patient's) medical status. _____ *(Initial)*

In the event of an emergency please contact:
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Doctor's Notes:

Medical/dental health reviewed by:

X _____ _____
Doctor's Signature *Date*

_____
Patient's Signature (If patient is a minor: Parent/Guardian's signature)

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• ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this Office Notice of Privacy Practices.

I, _____, authorize A Great Smile Dental to release any and or all of my dental/medical information to the following recipients listed below:

_____

_____

_____
Signature

_____
Date

• FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify Below)

_____

_____ _____
Employee Signature Date