

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 out 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,

Ben Yaghmai, D.D.S. and the AGSD Team

• 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 _____

• **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 <input type="checkbox"/> Home <input type="checkbox"/> 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 <input type="checkbox"/> Home <input type="checkbox"/> 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 <input type="checkbox"/> Home <input type="checkbox"/> Mobile	

How did you find our office?

- Referred by a friend/relative
 Insurance
 ZocDoc
 Yelp
 Other (please explain): _____
 Living in the Neighborhood
 FaceBook
 Google Search

Who should we thank for referring you to our practice? _____

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 your mouth?
14. Y N I enjoy different forms of sweets on a daily basis? (eg: soda, energy drinks, chocolate, etc?)

• **PATIENT'S HEALTH HISTORY (cont.)**

<p>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?</p>	<p>62. Y N Do you have any other medical problems or medical history NOT listed on this form?</p> <hr/> <hr/> <hr/> <hr/> <hr/>
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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:

<p>Medical/dental health reviewed by:</p> <p>X _____ <small>Doctor's Signature</small> <small>Date</small></p>	<p>_____ Patient's Signature (If patient is a minor: Parent/Guardian's signature)</p>
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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