Alsamir Family Dentistry Patient Registration Forms

PERSONAL INFORMATION

Name _____ Date _____

SS# _____Date of Birth (mm/dd/yyyy) _____

Address_____

City_____ State_____ Zip_____

Sex _____ Marital Status _____ Spouse Name _____

Phone: Cell _____ Home _____ Work _____

E-Mail Address _____

Referred by _____

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

We would like to keep in touch regarding your upcoming appointments and treatment plans via emails and text messages. We will limit the type of information in the messages. To opt out of communications, follow prompts in emails/texts or call our practice phone number. **Patients are responsible for providing the practice with updates to email addresses and phone numbers.**

I agree to receive electronic communications via the email address and/or mobile number listed above.

Patient/Patient Representative Initials _____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of procedures, financial and scheduling information. Under the requirements of HIPAA ***we are not allowed to give this information to anyone without the patient's consent.*** If you wish to have your information released to any family members/caretakers, you must complete this form. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent. You are responsible for notifying us of any changes you would like to make to this list.

Name _____ Relation to Patient _____

Name _____ Relation to Patient _____

Name _____ Relation to Patient _____

Patient/Representative Signature _____Date _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relationship _____ SS# _____

Address _____

Phone: Cell _____ Home _____ Work _____

E-Mail Address _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co _____ Employer _____

Subscriber _____ Relationship _____ SS#_____ DOB _____

Claims Mailing Address _____

Group Number _____Policy Number _____

Secondary Insurance Co _____ Employer _____

Subscriber _____ Relationship _____ SS#_____ DOB _____

Claims Mailing Address _____

Group Number _____Policy Number _____

PRIVACY AGREEMENT

I authorize Alsamir Family Dentistry to release any information related to my dental care to my insurance company(s). This information will be used exclusively for the purpose of carrying out treatment and evaluating and administering claims for insurance benefits. I also acknowledge I have been given the opportunity to review and receive a copy of Alsamir Family Dentistry's Notices of Privacy Practices.

Patient/Representative Signature _____Date _____

CONSENT TO TREATMENT

I authorize Alsamir Family Dentistry to render dental services to me/my child or the patient I am representing. This includes x-rays, models, photographs, or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of the patient's dental needs. I authorize the dentist to perform any indicated treatment and provide any indicated medication or therapy.

Patient/Representative Signature _____Date _____

FINANCIAL AGREEMENT

We are committed to providing you with exceptional service and the highest quality lifetime dental care. The following is a statement of our financial policy, which we require you to read and sign prior to treatment. We are pleased to discuss our professional fees with you at any time. **Your clear understanding of this policy is important to our professional relationship and partnership to care for your oral health**. Please ask if you have any questions about our fees, financial policy or your responsibility.

Insurance & Payment at Time of Services

As your dental care provider, our relationship is with you, our patient, not with your insurance company. Alsamir Family Dentistry files insurance claims and provides cost estimations as a convenience to our patients. We will do all we can to make sure your estimate is as accurate as possible; however, we cannot guarantee your insurance will pay exactly as estimated, even if a pre-authorization has been filed. **You will be required to pay the estimated cost of services (including deductibles and copayments), as well as any prior account balance due at the time services are rendered.** Any patient financing arrangements must be made prior to services if you are unable to pay the balance in full. **If full or partial insurance payment is not received or your claim is denied,** you will receive a billing statement from our office indicating what your insurance has covered and the remaining patient account balance. **You will be responsible for paying the balance in full upon receipt**. A finance charge of 1.5% with a $3.00 minimum goes into effect after 30 days to cover the cost of rebilling. If the insurance company distributes payment to you instead of our practice, you become responsible for the total account balance and payment is expected immediately. **You are responsible for informing us of changes in insurance coverage prior to examination and/or treatment, or you may be responsible for any charges incurred due to delay in timely submission of your claims.** Please bring your dental insurance card to every visit. **If we cannot verify your insurance benefits eligibility prior to treatment, payment is expected in full prior to all services being rendered.** If insurance payments and the amount of your payment exceed the amount owed for services, the difference will be refunded back to you.

PATIENT INITIALS _____

Self-Pay

For patients who do not have dental insurance, full payment is prior to services being rendered. Please ask us about the discount membership plan we offer to patients without dental insurance.

PATIENT INITIALS _____

Canceled/Missed Appointments

If you are unable to keep your appointment, please contact our office at least 24 business hours prior to your scheduled appointment time. **If you cancel, reschedule or miss your appointment without 24 hours' notice, a $50 charge will be added to your account. New appointments cannot be scheduled until this charge is paid in full.**

PATIENT INITIALS _____

Fees

Billing Statements: If your statement balance has not been paid in full after 30 days of mailing, a finance charge of 1.5% with a $3.00 minimum goes into effect to cover the cost of rebilling. This will be applied to every subsequent rebilling.

Declined/Returned Payments: A $25 fee will be applied to your account for any checks rejected by the bank for any reason. If a pre-arranged credit card payment plan is established and a payment is declined, you may be charged $25 per declined transaction. Please ensure there are sufficient funds on the stored credit card to cover these payments prior to setting up payment arrangements and contact our office immediately with any changes regarding your stored card.

Delinquent Accounts: Should your account become delinquent, you will be responsible for paying all expenses relating to the collection proceeding, including court costs and attorney fees and collection agency fees. The collection agency fee is $50. All past due balances may accrue interest at the rate of our billing cycle policy (above) and you will also be responsible for this amount.

PATIENT INITIALS _____

By signing below, I confirm I have read and agree to the above terms and conditions. I acknowledge full financial responsibility for services rendered by Alsamir Family Dentistry. I authorize payment of insurance benefits directly to Alsamir Family Dentistry, otherwise payable to me. I understand my dental insurance may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts, including payments for services not covered in whole or part by my dental insurance, including co-pays, deductibles and coinsurance amounts, and that payments are expected at the time of service.

Patient/Representative Signature_____**Date**_____

Patient Name/Representative (printed)

_____

Alsamir Family Dentistry
13841 Hull St Rd Ste 1
Midlothian, VA 23112

Phone: (804) 739-5791
Fax: (804) 739-5793
email: info@alsamirfamilydentistry.com

MEDICAL HISTORY & GENERAL HEALTH INFORMATION

Before starting treatment, we need some basic health information to ensure we provide the best oral care possible. All information is confidential.

GENERAL INFORMATION

Patient Name:_____ Date of Birth*(MM/DD/YY)*:_____

Who is your Primary Care Physician(PCP)?_____ Last Exam Date:_____

Please list any medication(s) you are currently taking:_____

_____

Are you allergic to: Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Household Bleach

Please list any other allergies:_____

Have you ever taken: Phen-Fen Redux Fosamax Boniva Actonel Other Bisphosphonate:_____

Have you ever been hospitalized, had a major operation, or had a major injury to your head or neck? *Yes* *No*

_____

Are you taking any herbal suppplements or on a special diet? *Yes* *No* _____

Do you currently use or have you ever used tobacco products? *Yes* *No* _____

Do you use any controlled substances? *Yes* *No* _____

WOMEN

Are you currently pregnant or trying to get pregnant? *Yes* *No* Are you currently nursing? *Yes* *No*

Are you currently taking oral contraceptives? *Yes* *No* _____

MEDICAL CHECKLIST *(Please check all that apply)*

All information is kept strictly confidential.

AIDS/HIV Positive	Convulsions	Hepatitis A	Radiation Treatments
Alzheimer's Disease	Cortisone Medicine	Hepatitis B or C	Recent Weight Loss
Anaphylaxis	Diabetes	Herpes	Renal Dialysis
Anemia	Drug Addiction	High Blood Pressure	Rheumatic Fever
Angina	Emphysema	High Cholesterol	Scarlet Fever
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Shingles
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Sickle Cell Disease
Artificial Joint	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Asthma	Frequent Cough	Kidney Problems	Spina Bifida
Blood Disease	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Blood Transfusion	Frequent Headaches	Liver Disease	Stroke
Breathing Problems	Glaucoma	Low Blood Pressure	Swelling of Limbs
Bruise Easily	Hay Fever	Lung Disease	Thyroid Disease
Cancer	Heart Attack/Failure	Mitral Valve Prolapse	Tonsillitis
Chemotherapy	Heart Murmur	Osteoporosis	Tuberculosis
Chest Pains	Heart Pacemaker	Pain in Jaw Joints	Ulcers
Cold Sores/Fever Blisters	Heart Trouble/Disease	Parathyroid Disease	Yellow Jaundice
Congenital Heart Disorder	Hemophilia	Psychiatric Care	Other: *(please detail below)*

Have you had a serious illness not listed above? *Yes* *No* *If yes, please detail below*_____

_____

_____

CONSENT

I certify that the questions on this form have been answered accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my(or the patient's) health, and that it is my responsibility to notify the dental office of any changes in medical status. I also understand that this consent will remain in effect until treatment is terminated either by myself or the dentist.

*Printed Name of Patient (or Patient Representative):*_____

*Signature of Patient (or Patient Representative):*_____ *Date:*_____