



PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT LAST NAME: _____ FIRST: _____ INITIAL: _____

How do you wish to be addressed? _____ DOB _____

(Single Married Divorced) (Male Female) Full time Student? Yes No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

Is patient covered by another dental insurance? Yes No Insurance Co. _____

How did you hear about our practice? Whom may we thank for your referral? _____

HUSBAND, FATHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

WIFE, MOTHER OR RESPONSIBLE PARTY (IF OTHER THAN PARENT)

Last Name _____ First _____ Initial _____

Address _____ DOB _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

Email _____

Employer _____ Occupation _____

Soc. Sec. No. _____ Dental Insurance Co. _____ Group _____

NEAREST RELATIVE

Last Name _____ First _____ Initial _____

Address _____

City _____ State _____ Zip _____ E-Mail _____

Telephone (Home) _____ (Work) _____ (Mobile) _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. 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. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature _____ Date _____

PLEASE COMPLETE ALL INFORMATION – THANK YOU

PATIENT LAST NAME: _____ PATIENT FIRST NAME: _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental visit _____
 Former dentist _____ Date of last dental x-rays _____

Please check if you have/had:	Yes	No		Yes	No	
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Head, neck, jaw pain, or aches	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an allergic reaction to Novocaine, local, or general anesthetics? <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/>	<input type="checkbox"/>	Lip or cheek biting	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please explain _____
Burning sensation on tongue	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth or broken fillings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chew on one side of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cigarette, pipe, or cigar smoking	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smokeless tobacco	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food collection between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to pressure or irritants (cold, heat, sweets)	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had trouble from previous dental care? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain _____
Clench or grind teeth	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____			_____
Growths or sore spots in your mouth	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____			_____
Gums swollen, tender or bleeding	<input type="checkbox"/>	<input type="checkbox"/>				_____

MEDICAL HISTORY

Physician's name _____ Date of last visit _____
 Physician's address _____ Blood Pressure _____

Have you had any serious illnesses or operations Yes No If yes, please describe _____
 Have you ever had a blood transfusion Yes No If yes, give approximate dates _____
 (Women) Are you pregnant? Yes No Due date _____ Nursing? Yes No Taking birth control pills? Yes No

Please check if you have/had:	Yes	No		Yes	No		Yes	No
Allergies, hay fever, sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Slow healing wounds	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis type _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Required Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	Any immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head/neck	<input type="checkbox"/>	<input type="checkbox"/>
Have you used steroids	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Date of last episode _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally with operations or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss, unexplained	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease, clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Do you consume alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently under the care of a Physician?	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic/sensitive to Latex?	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatments	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to Penicillin, Aspirin, or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, please specify _____		
Cough, persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	List any medications that you are taking:		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	_____		

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature _____ Date _____
 Reviewed by: _____ Date _____



PATIENT HIPAA AWARENESS

With my permission, Dr.beheiry & Dr.Baghaei use and disclose protected health information(PHI) about me to carry out treatment, payment and healthcare operations(TPO). Please refer to Drs. Beheiry & Baghaei's Note of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Drs. Beheiry & Baghaei reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Drs. Beheiry & Baghaei may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission the office of Drs. Beheiry & Baghaei may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Or Confidential.

With my permission, the office of Drs. Beheiry & Baghaei may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Drs. Beheiry & Baghaei restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Drs. Beheiry & Baghaei to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- Statement of Actual Services Request for Predetermination/Preauthorization
 EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? Medical? (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender M F 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number 10. Patient's Relationship to Person named in #5
 Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender M F 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
 Self Spouse Dependent Child Other 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender M F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)										34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)		31a. Other Fee(s)						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____		32. Total Fee
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A") B _____ D _____		

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
 Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
 Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital) 39. Enclosures (Y or N)

40. Is Treatment for Orthodontics?
 No (Skip 41-42) Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment 43. Replacement of Prosthesis No Yes (Complete 44) 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
 Occupational illness/injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
 Signed (Treating Dentist) Date

54. NPI 55. License Number

56. Address, City, State, Zip Code 56a. Provider Specialty Code

57. Phone Number 58. Additional Provider ID



Appointment Policy

Our staff at iSmile Dental Care is committed to providing the highest quality of dental care and services for our patients. Dental procedures require preparation and planning. This includes appropriate staffing, treatment room availability and material preparation at specific times during our work day. We reserve specific time blocks in an attempt to meet patient schedules and the urgency of the dental need. If you have made an appointment with us, that time has been reserved exclusively for you and we have prepared in advance for your visit. Please be advised of the following requirements:

- We require 6: hours notice for cancellation of a scheduled appointment
- A cancellation fee of \$75.00 will be added for all missed or cancelled appointments with less than 48 hours notice. A ppointments longer than 60 m inutes will result in a higher fee
- If there are three missed or cancelled appointments without 6: hours notice appointments in a year time frame, we reserve the right to not schedule any further appointments or to require a deposit in order to schedule a future appointment.
- Family emergencies will be taken into consideration

Signature of patient (or responsible party)

Date