BADR DENTAL

Welcome to our Practice. Please complete the following information.

Name:
Address:
City: **Zipcode:**

Daytime Phone: _____ **Home** _____ **Cell**_____
Birthdate:_____ **SSN**: _____ **Driver License:**_____
Place of Employment:_____ **Phone:**_____
In case of emergency who can we contact:_____ **Phone:**_____
If the Patient is under 18 or is not the responsible paty, please complete the following information:
Responsible Person last name:_____ First name_____
Address(if different from above)_____
Date of Birth:_____Social Security Number:_____
Daytime Phone:_____Work:_____Cell:_____
Employment and address:_____
How did you hear about us?_____
Email Address:_____

Medical History

How is your health: (Excellent) (Good) (Fair) (Poor) Is your Blood Pressure: (High) (Low) (Normal)
Are you allergic to any medications? (Y) (N) If yes which one(s)_____
Are you taking any medications? (Y) (N) If yes please list_____
Have you had allergic reactions to Novocaine (Y) (N) or Lidocaine (Y) (N)?
Do you need PreMedication before dental treatment? (Y) (N)? Why?_____

Have you ever been treated for any of the following?

Please circle (Y) or (N)		**When**			**When**
Hepatitis A, B or C	(Y) (N)	_____	Artificial Joint(s)	(Y) (N)	_____
Epilepsy/Convulsions	(Y) (N)	_____	Tuberculosis	(Y) (N)	_____
Kidney Problems	(Y) (N)	_____	Veneral Disease	(Y) (N)	_____
Diabetes	(Y) (N)	_____	Rheumatic Fever	(Y) (N)	_____
Heart Trouble	(Y) (N)	_____	HIV/Aids	(Y) (N)	_____
Alcoholism	(Y) (N)	_____	Drug Addiction	(Y) (N)	_____
Kidney Problems	(Y) (N)	_____	Asthma	(Y) (N)	_____
Cancer	(Y) (N)	_____	Liver Problems	(Y) (N)	_____

Any other Medical Problems not listed?_____
Are you Pregnant or Nursing? Explain_____
Is there anything in your medical history that we need to be aware of?_____
Are you under a Physician care?_____ If so why?_____
Physician Name and Address_____Phone_____

Dental History

What is the reason for your visit?_____
Are you in pain?_____ If so, where? Upper_____Lower_____Left_____Right_____
When was your last dental exam?_____ Cleaning?_____ X-rays_____
Do like your smile?_____ If no, what would you like to change?_____
Do you have popping and clicking in your jaw?_____
Any problems associated with dental treatment?_____ If yes, what?_____

Patient/Guardian Signature:_____

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Smile Evaluation

We would like to help you obtain the smile you have always wanted. Please take a few minutes to complete the short Smile Evaluation. While using a mirror or looking a photograph, please observe your teeth carefully.

1. Are you pleased with the appearance of your teeth when you smile?

   _____

2. Do you have any concerns about bad breath?

   _____

3. Are there spaces between your teeth that you do not like?

   _____

4. Are you pleased with the color of your teeth?

   _____

5. Are you pleased with the shape of your teeth?

   _____

6. Are you teeth:

   Chipped?_____ Protruding?_____ Hidden?_____ Crowded?_____

7. Do you like the way your teeth fit together when you bite?

   _____

8. Are there old fillings or dental treatment that you are not happy with?

   _____

9. What would you change (if anything) about your smile?

   _____

10. Would you like to see how your smile could look different?

    _____

BADR DENTAL

Financial Policy

Badr Dental's financial policy is outlined to assure maximum dental care with minimal confusion in the delivery of your dental treatment. Below is our Financial Policy that is outlined for your review. If you have any questions concerning any of the information please bring it to our attention.

_____1. Badr Dental will obtain an **Estimate of Benefits** from your insurance provider for treatment that is rendered. **Thist is not a guarantee of benefits**. We are not responsible for any variation in the actual payment or unforeseen policy provisions that may affect payment from your insurance company. **ANY AMUNT NOT PAID BY THE INSURANCE COMPANY WITHIN 45 DAYS IS THE PATIENT'S RESPONSIBILITY TO BE PAID IN FULL.**

_____2. I shall keep all scheduled appointments. I understand that when I make an appointment, that time has been set aside time for me. **If I break my scheduled appointment without a 24 hour notice I understand and agree to pay a broken appointment fee of $40.00 per appointment.**

_____3. I understand that a **deposit for all major appointments is required.**

_____4 Badr Dental processed all checks electronically, if the check is returned a **$35.00** return check fee will be charged and must be paid immediately. We will reserve the right not to accepter further checks for co-payments.

_____5. Payment is due at the time services are rendered. We accept cash, check, money orders, credit cards (Visa, Mastercard, Discover, American express). We also work with Finance companys that offer financing with **approval of credit.**

_____6. Any payments made by the Insurance Company to yourself or the insured must be signed over to Badr Dental unless payment in full has been previously received by our office.

_____7. I have read and understand all of the financial policy provisions outlined above by Badr Dental. I take full responsibility for my account and knowledge of my insurance provisions.

_____ _____

Patient/Guardian Signature Date

_____ _____

Smile Coordinator Date

BADR DENTAL

Notice of Privacy Practices
This notice describes how health information about you may be used and disclosed and you can get access to this information.

Please review it carefully
The privacy of your health information is important to us.

Our legal Duty
We are required by applicable federal and state law to maintain the privacy of you health information. We are also required to give you this notice about our privacy practices, our legal duties, and you rights concerning you health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notices takes effect 4/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or the additional copies of this Notice, please contact us using the information at the end of this Notice.

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment, and healthcare operations, For example:

Treatment: We may use and disclose your health information to obtain payment for services we provide you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accretidation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment of healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.