New Smile Dentistry, PA

Firas Marouf, D.M.D.

620 W SR 434 Winter Springs, FL 32708
Call **407-327-0731** Fax **407-327-1018** Web **www.NewSmileDentistry.net**

WELCOME TO OUR OFFICE - TELL US ABOUT YOURSELF

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ Male: ☐ Female: ☐

Address: _____ City: _____ State: ____ Zip: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email : _____

Employer: _____ Occupation: _____

Employer Address: _____

Marital Status - *please circle one:* ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

Spouse's Name: _____ Spouse's SSN: _____

How did you hear about our office? - *please check one:*

FRIEND ☐ POSTCARD ☐ BILLBOARD ☐ DRIVE-BY ☐ MAGAZINE ☐ SEARCH ENGINE ☐ FACEBOOK ☐ INSURANCE ☐

OTHER: _____

PRIMARY INSURANCE INFORMATION

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to New Smile Dentistry, PA all insurance benefits, if any, otherwise payable, to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary including medical records to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentists that are necessary for proper dental care. The dentists and staff are not responsible for any treatment failures that are the result of patient neglect, injury or abuse.

Patient / Guardian Signature: _____ Date: _____

MEDICAL HISTORY

Do you have a personal physician? Yes: ☐ No: ☐ Physician's Name: _____

Physician's Phone: _____ Date Of Last Visit: _____

Your current physical health? Good: ☐ Fair: ☐ Poor: ☐ Currently under the care of a physician? Yes: ☐ No: ☐

Please Explain: _____

Do you use tobacco in any form? Yes: ☐ No: ☐ Any metal rods, pins or implants placed? Yes: ☐ No: ☐

Are you taking any medications? Yes: ☐ No: ☐

Please list each one:

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING?

Yes	No	CONDITIONS
☐	☐	Abnormal bleeding
☐	☐	Alcohol abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina pectoris
☐	☐	Arthritis
☐	☐	Artificial heart valve
☐	☐	Asthma
☐	☐	Blood transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital heart disease
☐	☐	Diabetes
☐	☐	Difficulty breathing
☐	☐	Drug abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial surgery
☐	☐	Fainting spells
☐	☐	Fever blisters
☐	☐	Frequent headaches

Yes	No	CONDITIONS
☐	☐	Glaucoma
☐	☐	HIV + AIDS
☐	☐	Heart attack
☐	☐	Heart murmur
☐	☐	Heart surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High blood pressure
☐	☐	Joint replacement
☐	☐	Kidney problems
☐	☐	Liver disease
☐	☐	Low blood pressure
☐	☐	Mitral valve prolapse
☐	☐	Pace maker
☐	☐	Psychiatric problems
☐	☐	Radiation therapy
☐	☐	Rheumatic fever
☐	☐	Seizures
☐	☐	Sexual transmitted disease
☐	☐	Shingles

Yes	No	CONDITIONS
☐	☐	Sickle cell disease
☐	☐	Sinus problems
☐	☐	Stroke
☐	☐	Thyroid problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	**ALLERGIES**
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry / Metals
☑	☐	Latex
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other

Yes	No	IF FEMALE, PLEASE ANSWER
☐	☐	Taking birth control pills?
☐	☐	Are you pregnant?
		If so, how many weeks? _____
☐	☐	Are You Nursing?

Person to contact in case of emergency: _____ Relationship: _____

Address: _____ Phone Number: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my medical status since dentist and staff will rely on this information for treating me.

Signature: _____ Date: _____

DENTAL HISTORY

How may we help you today?

Your current physical health? Good ☐ Fair ☐ Poor ☐

Require antibiotics before dental treatment? Yes ☐ No ☐

Are you currently in pain? Yes ☐ No ☐

Have you ever had gum treatment? Yes ☐ No ☐

Do you now, or have you had, any pain or discomfort in your jaw joint? (TMJ) Yes ☐ No ☐

Are you under any stress? (new job, moving, relationships, etc.) Yes ☐ No ☐

Do you like your smile? Yes ☐ No ☐

Is there anything you would like to change about your smile? Yes ☐ No ☐

Are you happy with the color of your teeth? Yes ☐ No ☐

Do your gums bleed? Yes ☐ No ☐

How many times do you: Floss per week? _____ Brush per day? _____

Are your teeth sensitive to heat, cold, or anything else? Yes ☐ No ☐

Have you lost any teeth? Yes ☐ No ☐

Have you ever had a serious/difficult problem with any previous dental work? Yes ☐ No ☐

Have you ever had any unfavorable dental experiences? Yes ☐ No ☐

When was your last dental cleaning? _____

When was your last dental visit? _____

When did you leave your previous dentist? _____

How can we accommodate you better during your dental visit?

Here at Jackson Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please check any services below you would like our friendly staff to discuss with you during your visit.

- ☐ TEETH WHITENING
- ☐ VENEERS / LUMINEERS®
- ☐ DENTAL IMPLANTS
- ☐ SMILE MAKEOVER
- ☐ FULL-MOUTH IMPLANTS
- ☐ SEALANTS
- ☐ CROWN AND BRIDGE
- ☐ BONDING
- ☐ PARTIALS / DENTURES
- ☐ NIGHT / SPORT GUARDS
- ☐ ORTHODONTICS (BRACES/INVISALIGN®)
- ☐ IMPLANT DENTURES

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FINANCIAL POLICY

We are pleased that you have selected us as your dental care provider. Please find our Financial Policy is outlined below.

Promise to Pay: Amounts for dental care services provided to you or your family members may be charged to your Account, unless you specifically instruct us otherwise. You promise to pay us all amounts owed on your Account (your "Balance") under the terms of this Financial Policy when billed. If you have dental insurance, the amount you owe for services may be estimated based on the amount anticipated to be paid by your insurance company. We will assist you with a dental insurance claim as long as the correct insurance information is given before time of service. If there is a change in insurance we ask you provide us with the updated information 24 hours in advance. We do not accept or file Medical Insurance. If you have a secondary insurance you will be expected to pay your portion based on your primary insurance only. As a courtesy we will help you file your secondary insurance claim, but the payment will be made directly to the insured member of the secondary insurance. Insurance is a contract between the policy holder and insurance company. The anticipated amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. However, in the event your insurance company is slow to pay or disallows a claim, payment of your Account is your full responsibility. We may also charge to your Account fees set forth below for missed appointments, late payments, returned payments or collection costs. We will provide to you a statement (your "Statement") of your Balance, which will be payable when you receive your Statement. We may indicate on your Statement that your Balance is "pending insurance" and thus not yet payable by you. If you have insurance coverage, we may choose not to send you a Statement until we know or receive the amount reimbursable by your insurance company.

Missed Appointment Fee: We may charge to your Account fees for a missed appointment or fees for an appointment cancelled without advance notice of at least 48 hours.

Late Payment and returned payment Fee: If we do not receive payment in full of your Balance within 30 days of the statement date shown on your Statement, you will be assessed a Late Payment Fee of 2.00% of your unpaid Balance each month. We may not allow further appointments, unless in exceptional circumstances, until we receive full payment of your Balance. If any check or other payment that you have made on your Account is returned unpaid, you will be charged a Returned Payment Fee, which is currently $45.00 and may be adjusted due to fluctuating bank charges.

Collection Cost: If we do not receive payment under the terms of this Financial Policy and we refer your Account to a collection agency or an attorney for collection, we may charge to your Account or otherwise collect from you our collection costs, including court costs and reasonable attorneys' fees, to the extent not prohibited by applicable law.

No Waiver by Us: We may waive our right to charge a fee to your Account without waiving any other right we have under this Financial Policy including our right to charge that same fee at any other time.

Credit Reports: We, or a collection agency or attorney acting on our behalf, may report late payments, missed payments or other defaults on your account to credit reporting agencies. If you believe that we have information about you that is inaccurate or that we have reported or may report inaccurate information to a collection agency, please notify us of the specific information that you believe is inaccurate by writing to us at the address above.

Account on file: New Smile Dentistry, PA may keep your Credit Card Or CareCredit accounts on file and has the right to charge these accounts for any nonpaid past due balance without any advanced notice to you, but a receipt will be mailed to you.

As used in this Financial Policy, "we," "us," "our" and "Provider" mean the service provider named above (New Smile dentistry, PA). "Services" means any services provided by us. "You," "your' and "Account holder" mean the person responsible for paying for services. Payment for services is due when services are provided unless as noted otherwise above. By signing below, you are requesting that we establish an open account for you (your "Account") as an accommodation to you for the tracking and payment of amounts due and you agree to the terms of this Financial Policy.

Name:_____ Signature:_____ Date:_____

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CANCELLATION AND NO-SHOW POLICY

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental “clinic.” Appointment time is reserved for you alone.

Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will be understanding of the situation. At some point, they may need the same courtesy too!

Like many offices, this office does call to confirm your appointment. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. **There will be a charge of $35 per 45 minutes of scheduled time for a broken appointment or cancellation with less than 48 hour notice for your appointment.**

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

Patient Signature: _____ Date: _____

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HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our Website. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

•Protected health information may be disclosed or used for treatment, payment or health care operations.

•The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

•The Practice reserves the right to change the Notice of Privacy Policies.

•The Patient has the right to restrict the uses of their information.

•The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.

•The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

This HIPAA Consent was signed by: _____ Date: _____

Print Name: _____

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MUST BE READ, INITIALED, AND SIGNED BEFORE PROCEDURE IS STARTED
NEW SMILE DENTISTRY, PA – GENERAL DENTISTRY INFORMED CONSENT

PATIENT NAME: _____

1. WORK TO BE DONE
I understand that I am having the following work done: Fillings ( ), Crowns ( ), Extractions ( ),Impacted teeth removed ( ), Root canals ( ), X-rays ( ), Dentures ( ), Other.

(Initials _____)

2. DRUGS AND MEDICATION
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock.

(Initials _____)

3. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials _____)

4. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.), and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, MPS, tongue and surrounding tissue (paresthesia) that can last for an indefmite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

(Initials _____)

5. CROWNS, BRIDGES AND CAPS
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

(Initials _____)

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally the canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses present in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy) I understand that the tooth may be lost in spite of all efforts to save it.

(Initials _____)

7. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials _____)

8. FILLINGS

I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly planted filling.

(Initials _____)

9. DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be necessary later. This is not included in the denture fee. I understand that failure to keep delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.

(Initials _____)

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restoration and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. Patient acknowledges receiving a signed copy of this document.

Signature of Patient: _____ **Date:** _____