Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone (____) _____ Cell Phone (____) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate_____ Soc. Sec. #_____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate_____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

ALLERGIES

_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Ghanbari & Koshki, D.D.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I, _____, have received a copy of this office's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)

_____

_____

Ghanbari & Koshki, D.D.S., P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Ghanbari & Koshki, D.D.S., P.C.
5727 Centre Square Drive, Centreville, VA 20120 703-803-9200

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or credit at the time services are performed.

Our office will help prepare the patients dental insurance forms or assist in making collections from their insurance companies and will credit any such collections to the patient's account. However**, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Patients who carry dental insurance understand that he or she is personally responsible for payment of all services thereafter.**

A service charge of 1.5% per month (**18%** per annum) on the unpaid balance will be charged on all accounts exceeding 9 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by Dr. Ghanbari and Associates, I agree to pay therefore the reasonable value of said services to said Provider, at the time said services are rendered, or within (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suite be instituted hereunder.

I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and treatment and payment and agree to their consent.

Please Print Name of Patient, Parent or Guardian/Guarantor of Payment: Relationship to Patient:

Signature of the above

Date

****We reserve the right to charge $60 for a Broken Appointment without 48 hours' notice****

GHANBRI & KOSHKI, D.D.S., P.C.
OFFICE POLICY

INDEMNITY AND PPO INSURANCE

As a courtesy to our valued patients, our office WILL DIRECTLY BILL THE INDEMNITY AND PPO INSURANCE for any treatment. **Patients need to be prepared to make any co-payments at the time services are rendered**. Our practice is committed to providing the best treatment for our patients and we charge what is usual customary for our area**. Please understand that you are fully responsible for all treatments rendered which includes services payable & non payable by your insurance company as determined by your insurance plan.**

DISCOUNTED FEE SCHEDULES

Discounted plans allow patients to receive dental service at a reduced fee. IN ACCORDANCE WITH YOUR CONTRACT, **PAYMENT IN FULL IS REQUIRED AT THE TIME THAT SERVICES ARE RENDERED.**

TYPES OF PAYMENT ACCEPTED

- CASH AND CHECKS **($30.00 FEE FOR RETURNED CHECKS)**
- MAJOR CREDIT CARDS
- **CARE CREDIT**

SCHEULING AND CANCELLATIONS

Because we value the time spent with our patients, appointments that you make are reserved solely for YOU AND THE DOCTOR. Please give our office the consideration to fill your reservation, if you need to cancel. Allow our office at least **48 BUSINESS HOURS** advance notice for any cancellation. PLEASE NOTE: SATURDAY AND SUNDAY DO NOT CONSTITUTE BUSINESS DAYS**. There will be a $60.00 broken appointment fee per HOUR!**

FINANCIAL AGREEMENT/PAYMENT POLICY

To the best of my knowledge, the information I have provided to this complete and accurate. I acknowledge that ALL charges incurred in the office are my responsibility. Should my insurance, for any reason, fail to pay any charges billed, I am fully responsible to pay for all my charges owed on my account. I understand that if my account remains unpaid for a period of 30 days. If any account remains unpaid for a period of 60 days, it may be referred to an attorney for collections, and that I further agree to be responsible and pay for all costs incurred, including a 35% attorney's fees (minimum of $50.00) and interest at 1/5% per month(18% per annum).

REQUESTS FOR RECORDS

All patient records are the legal property of the doctor; however, we will gladly provide you with copies of your x-rays. In accordance with your dental plan and state guideline, there will be a fee of **$35.00** per sheet. Treatment records are computerized and we will gladly provide you with a complete listing of services performed upon request. Please give us 24 hours for the turnaround time.

TREATMENT OF MINORS

All patients under the age of 18 must be accompanied by an adult who must remain in the office during the duration of the treatment. Children who are "dropped off" for treatment by a parent or guardian will not be seen. Please note that legally we are not able to make any exceptions to this policy. You may not leave your child/children unattended while you are receiving treatment.

RECOMMENDED TREATMENT MAINTENANCE

Although, the office assists you with reminder letters or telephone call, it is your responsibility to complete the treatment plan and to follow the recommended treatment maintenance program.

Once a new crown, bridge, denture or partial has been started it is the patient's responsibility to return with the recommended time for treatment completion. If you require that the crown, bridge, denture or partial be remade because of your failure to return to the office for treatment, you will be responsible for all previous charges and all additional charges involved in the remaking.

Please Print Name: _____

Patient/ Guardian Signature: _____ **Date:** _____