Broadview Dentistry
Majdi I. Alrabady, DDS, BDS, FAGD
9341 Broadview Rd, Broadview Hts, OH 44147
(440) 526-1000

Medical Alert:

Thank you for choosing us for your dental care! Please fill out all sections of this confidential form.
Your information is never shared and kept strictly confidential. If you have any questions or require assistance, please ask!

1. Patient Information

How did you hear about our office? ____________________

Who may we thank for referring you to our office? ____________________

Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Gender:** ☐ Male ☐ Female

Patient Name: FIRST ____________ MI______ LAST____________

Address ____________Apt______ City ____________ State ______ Zip ________

Birthdate: ____________ Social Security Number: ____________

Home Phone ____________ Cell Phone ____________

Email ____________ Work Phone ____________

Employer ____________ City ____________ Occupation ____________

Emergency Contact Person ____________ Relation to Patient ________ Phone # ________

PHONE NUMBER where patient/guardian can be reached ***DURING THE DAY*:** ☐ Home ☐ Cell ☐ Work

2. Dental Insurance

Do you have dental insurance coverage? ☐ Yes ☐ No -- ***If no, skip to section 3.***

Primary Insurance Co.____________ Phone ____________ Address ____________

Subscriber Name____________ Subscriber Birthdate ________ Subscriber SSN #: ________

Subscriber ID#____________ Group # ________ Employer/Group Name:____________

Secondary Insurance Co.____________ Phone ____________ Address ____________

Subscriber Name____________ Subscriber Birthdate ________ Subscriber SSN #: ________

Subscriber ID#____________ Group # ________ Employer/Group Name:____________

3. (for Child/Dependent Patient) Responsible Party

Father's Name____________ ☐ Biological ☐ Other ________

Address ____________Apt # ______City ____________State:_____ Zip________

Home Phone ____________ Work Phone ____________Cell Phone ____________

Social Security Number ____________ Birthdate ____________

Employer ____________Occupation ____________

Mother's Name____________ ☐ Biological ☐ Other ________

Address ____________Apt # ______City ____________State:_____ Zip________

Home Phone ____________ Work Phone ____________Cell Phone ____________

Social Security Number ____________ Birthdate ____________

Employer ____________Occupation ____________

***** Person financially responsible for this account/ Phone number (if other than parents listed above)***

____

(Please also complete the back of this form)

Patient First Name: ______________________ Last Name: _________________________ DOB____________

4. Personal Medical History (check Yes or No for medical conditions currently or in the past)

Condition	Yes / No
AIDS/HIV Positive	□Yes □ No
Alcoholism	□Yes □ No
Anemia	□Yes □ No
Arthritis	□Yes □ No
Asthma	□Yes □ No
Bone Disease	□Yes □ No
Chemical Dependency	□Yes □ No
Chest Pain	□Yes □ No
Circulatory Problems	□Yes □ No
Convulsions/Seizures	□Yes □ No
Diabetes	□Yes □ No
Excessive Bleeding	□Yes □ No
Epilepsy	□Yes □ No
Frequent Headaches	□Yes □ No
Hearing Impaired	□Yes □ No
Heart Disease	□Yes □ No
Heart Valve, Murmur	□Yes □ No
Hepatitis/Liver Disease	□Yes □ No
Hepatitis Carrier	□Yes □ No
High Blood Pressure	□Yes □ No
Kidney Disease	□Yes □ No
Kidney Dialysis	□Yes □ No
Latex Sensitivity	□Yes □ No
Lupus	□Yes □ No
Low Blood Pressure	□Yes □ No
Malignancies	□Yes □ No
Neck & Back Problems	□Yes □ No
Nervous Problems	□Yes □ No
Pacemaker	□Yes □ No
Psychiatric Care	□Yes □ No
Radiation Treatments	□Yes □ No
Respiratory Problems	□Yes □ No
Rheumatic Fever	□Yes □ No
Scarlet Fever	□Yes □ No
Sinus Problems	□Yes □ No
Stroke	□Yes □ No
Thyroid Disease	□Yes □ No
Tuberculosis	□Yes □ No
Ulcers	□Yes □ No
Venereal Disease	□Yes □ No

Are you in general good health? □Yes □ No

Are you a smoker? □Yes □ No

Are there any problems not listed you would like to discuss? □Yes □ No

____

Primary Care Physician's Name

____

City__________________________

Organ/Valve/Joint/ Replacement and/or Implant: □Yes □ No If Yes, Type:______________________________

Doctor: ____ Date: ______________________________

Cancer: □Yes □ No If Yes, Type:____

Allergies: □ None □ Penicillin □ Latex □ Metals □ Aspirin □ Sulfa □ Other ____________________

Medications: Any currently being taken? □No □ Yes: Please list all medications or attach list: ____________________

____

(Women) Is there a possibility of pregnancy? □ Yes □ No, If Yes, how far along? __________ Due Date:__________

5. Dental History

What is the reason for this visit?____

How long since your last dental visit? ______________ What was done at that time?________________________

Previous Dentist ______________________________ City__________________________Phone______________

How long since your teeth were cleaned at a dental office? ________________Were dental x-rays taken? □ Yes □ No

Are your teeth sensitive to: □Hot? □ Cold? □Sweets? □ Pressure? □ No teeth sensitivity

Bleeding of Gums □Yes □ No, If Yes, when? ______________________________________

Have you lost any teeth or have any teeth been removed? □ Yes □ No

Have missing teeth been replaced? □ Yes □ No, If Yes, are you unhappy with the replacement? □Yes □No

Do you clench or grind your teeth? □Yes □ No

Jaw Pain, does Jaw click or pop? □Yes □ No

Snoring, Mouth breather □Yes □ No

Prior Orthodontic Treatment □Yes □ No

If Yes, at what age? ________

Have you ever had any problems or complications with previous dental treatment? □ No □ Yes: If yes, please explain:

____

Are you unhappy with the appearance of your teeth? □Yes □ No If yes, what would you change?

____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my or my dependent's medical status. **I authorize the staff to perform the necessary dental services that the patient may need and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company or for legal documentation.**

Signature____________________________________ Date______________ Relationship: □Self □ Parent □Guardian

Reviewed By:_________________________________ Date______________

Broadview Dentistry

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement and Consent

Why do we ask you to sign this form?
1) To acknowledge that you have today either received or reviewed a copy of our notice of privacy practices.
2) To consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment, for example, sending your information to your insurance company or to a referred specialist.

- I acknowledge that I have the opportunity to request a copy of the Notice of Privacy Practices.
- I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.
- I give my permission for voicemail messages to be left for me at my provided home phone(s) or wireless phone(s)
- I also give consent for my treatment, appointments, insurance benefits, and financials to be discussed with the following individuals: **(e.g. spouse, parent, adult child, caregiver, or insurance policy holder)**

____

______________________________ ______________________________

Patient Signature | Patient/Guardian Name (please print)

Date: ____________________

For office use only

_____Patient refused to sign. ______________________________

The following circumstances prohibited the patient from signing the Acknowledgement:

____

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

______________________________ ______________________________

Office Personnel (signature) | Office Personnel (print name)

Date: ______________________________

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FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in a person's health, well-being, and self-esteem. We are always available to answer your questions or assist you in any way we can. To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding dental treatment and insurance.

Accepted forms of Payment: We accept Cash, Checks, Debit Cards, Credit Cards (Visa/MC/Disc/AMEX).

Payment Terms:

1. **Full Pay of balance is required at the time the service is delivered**, some exceptions below.
2. **Major Services requiring a case to be sent to the lab** (Crown, Bridge, Denture, Implant, and Veneer):
   a. **Two Payment Option**: We offer a two-payment option. We ask that you pay one-half of your co-payment at the first preparation appointment and the second half at your next appointment when the case is delivered or seated.
   b. **Credit Card Pay-in-advance**: With a signed agreement form, this Credit Card Payment Option allows you to make installments by credit card IN ADVANCE of beginning with the major services you opted for. Select a bi-weekly or monthly amount that will work for you and our office personnel will charge these payments to your credit card on the due dates and your account will be credited. PLEASE BE ADVISED that using this option, the services will be started when enough credit has been accumulated in the account to cover the balance of the treatment.
3. **Orthodontic Services:** For long term treatment such as orthodontics, we offer long-term in-house automatic credit card authorization plans customized for you.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. **Our office makes every effort to give you an accurate estimate of what your portion of the fees will be based on the information provided to us by your insurance company. We cannot guarantee or ensure what the actual terms of your policy are.** Please be aware that some, or perhaps all, of the services provided may be non-covered services and your insurance will not pay for it. In this case you are responsible for the balance of the account. For plans where we are a participating provider, we accept assignment of insurance benefits; therefore, all co-pays and deductibles are due prior to treatment. However, **the entire balance of the treatment is your responsibility whether your insurance company pays as estimated or not.** If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to you. YOU ARE RESPONSIBLE TO INFORM US OF ANY INSURANCE CHANGE OR CANCELLATION.

CHECKS: A returned check fee of $35 is charged to your account in the event that your financial institution returns the check for insufficient funds.

PAST DUE ACCOUNTS: If the account becomes 90 days past due, the account may be sent to a collection agency and a collection fee of 30% of the balance will be added on to the balance. The balance may be reported to credit bureaus.

MINORS: The parents/guardians of a minor are responsible for full payment of Patient responsibility at the time of service

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS.

Patient name:___________________________________

*SIGNATURE:*____ *DATE:* _________________________