Ivory Dental

Shaista Najmi, DMD

Patient Information

Last Name _____ *DOB* _____ *M ale* ☐ *Female* ☐

First Name _____ *SSN* _____

Address _____ *City* _____ *State* _____ *Zip* _____

Married ☐ *Divorced* ☐ *Single* ☐ *Other* ☐

Email _____

Home Phone # _____ *Employer* _____

Work Phone # _____ *Occupation* _____

Cell Phone # _____ *Emergency Contact:*

Name _____

Phone # _____

Dental Insurance Policy Holder

Ins. Company Name _____

Insurance Phone # _____

Insured Name _____

Insured DOB _____ *ID Number* _____

Insured Employer _____

◯ ***I herby authorize assignment of insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.***

Referral Source:

Money Pages ◯ *Drive By* ◯ *Yellow Pages* ◯

Mint Magizine ◯ *Post Card* ◯ *Friend/Relative* ◯

Insurance Company ◯ *Internet* ◯ *Name:* _____

How do you want to be contacted appointment reminder?

Home Phone ◯ *Email* ◯

Work Phone ◯ *Cell Phone* ◯

Patient Signature _____

Doctor Signature _____

Date: _____

Ivory Dental

Shaista Najmi, DMD

Medical History

Patient Name _____ *Physician Name/Phone #* _____

Previous Dentist _____ *Last Physician Visit Date* _____

Reason for Leaving Previous Dentist: _____

HEART PROBLEMS

- ***Chest Pain*** ◯
- ***Shortness of Breath*** ◯
- ***Heart Murmur*** ◯
- ***Heart Valve Problem*** ◯
- ***Rheumatic Fever*** ◯
- ***Pacemaker*** ◯
- ***Artificial Heart Valve*** ◯
- ***Taking Heart Medication*** ◯

List Other: _____

BLOOD PROBLEMS

- ***Easy Bruising*** ◯
- ***Frequent Nose Bleeds*** ◯
- ***Abnormal Bleeding*** ◯
- ***Blood Disease (Anemia)*** ◯

ALLERGY PROBLEMS

- ***Hay Fever*** ◯
- ***Sinus Problems*** ◯
- ***Skin Rashes*** ◯
- ***Taking Allergy Medicine*** ◯
- ***Asthma*** ◯

INTESTINAL PROBLEMS

- ***Ulcers*** ◯
- ***Weight Gain or Loss*** ◯
- ***Constipation*** ◯

BONE OR JOINT PROBLEMS

- ***Arthritis*** ◯
- ***Back or Neck Pain*** ◯
- ***Joint Replacement*** ◯

- ◯ ***Pins or Metal Rods***
- ◯ ***Diabetes***
- ◯ ***Tuberculosis or Other Respiratory Disease***
- ◯ ***Cancer Tumor***
- ◯ ***Hepatitis, Jaundice or Liver Problems***
- ◯ ***Herpes***
- ◯ ***HIV Positive/AIDS***
- ◯ ***Glaucoma***
- ◯ ***Thyroid Problems***

Have you been hospitalized during the past 5 years?

Yes ◯ ***No*** ◯

Do you have any disease, problem, or condition not listed?

Yes ◯ ***No*** ◯ _____

Do you have any Psychiatric Problems? Yes ◯ ***No*** ◯

During the past 12 months have you taken any of the following?

- ◯ ***Antibiotics or Sulfa Drugs***
- ◯ ***Anticoagulants***
- ◯ ***High Blood Pressure Medicine***
- ◯ ***Tranquilizers***
- ◯ ***Insulin, Ironies or similar drug***
- ◯ ***Aspirin (daily)***
- ◯ ***Digitals or drugs for heart problems***
- ◯ ***Nitroglycerine***
- ◯ ***Cortisone (Steroids)***

List of Meds taken daily: _____

WOMEN:

- ◯ ***Taking Contraceptives?***
- ◯ ***Other Hormones?***
- ◯ ***Pregnant? Due Date:*** _____

ARE YOU ALLERGIC TO THE FOLLOWING?

Local Anesthetic ◯ ***Codeine*** ◯ ***Sulfa Drugs*** ◯ ***Latex*** ◯

Barbiurate, Sedatives, or Sleeping Pills ◯ ***Penicillin or Other Antibiotics*** ◯

Patient Signature _____

Doctor Signature _____

Date: _____

Ivory Dental

Shaista Najmi, DMD

DENTAL HEALTH HISTORY

Patient Name _____

The information you provide is important for your dental health. If there have been any changes in your health, ***please tell us****. If you have any questions, do not hesitate to ask. Please answer Yes or No to the following questions:*

Are you having discomfort? Yes◯ No◯ Are your teeth turning yellow or losing brightness? Yes◯ No ◯
Any sensitivity to hot, cold, sweets, or chewing? Yes◯ No ◯ Do you smoke: Yes ◯ No ◯
Does dental treatment make you nervous? Yes◯ No◯ Do you drink coffee or tea? Yes ◯ No◯

Have you experienced any of the following problems?

Snoring Problem ◯
Bleeding Gums ◯
Bad Breath ◯
Grinding Teeth ◯
Other: _____

If I could change my smile I would make my teeth:

Whiter ◯
Close Space ◯
Replace Stained Front Filling ◯
Change Silver filling to white ◯
Repair Chipped Teeth ◯
Other: _____

Arthritis ◯
Difficulty in reaching back teeth ◯
Uncontrolled hand movement ◯

Do you take a fluoride supplement? Yes ◯No ◯
Do you prefer to save your teeth? Yes ◯No ◯
Have you had a special coating applied to your back teeth? Yes◯ No ◯

Date of last cleaning*:* _____

Have you ever had Periodontal Therapy done? Yes◯ No◯

DENTURE AND PARTIAL PATIENTS

Do you wear a denture/partial? Yes◯ No◯ *How old is you denture/partial?* _____
Do you use denture cleaner? Yes◯ No◯ *Do you use any denture adhesive? Yes ◯ No ◯*
Have you relined your dentures before? Yes◯ No◯ *Are your dentures loose? Yes◯ No◯*
Does your denture cause any irritation or soreness? Yes ◯ No◯
Have your dentures ever cracked or broken? Yes ◯ No◯
If you wear a partial, did you ever break a clasp? Yes◯ No◯

Please explain reason for your visit to our office today:

_____

How many times a day do you brush? _____ *How many times a week do you floss?* _____
What type of toothbrush do you use? _____
On a scale of 1 to 10 (10 being the best) How would you rate your smile? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health provider or agency who may release such information to you. I will notify the doctor for any change in my health or medication.

Patient Signature *Doctor Signature*

_____ _____

Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronic, on paper, or orally, be kept properly confidential. This act gives you, the patient, significant rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we man use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more health care providers. An example of this would include referring to a specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilizing review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspect of running our practice, such as conducting quality assessment and improvement activities, including functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosers will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Shaista Najmi, DMD

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICE.

****I have received a copy of the Notice of Privacy Practices of Ivory Dental**

Patient's Name

Signature

Date

Parent or Legal Guardian Name (if under 18 years of age

Signature

Date

You may refuse to Sign This Acknowledgement

For Office Use Only

We attempt to obtain written acknowledgement or receipt of our Joint Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ⬭ **Individual refused to sign**
- ⬭ **Communication barriers prohibited obtaining the acknowledgement**
- ⬭ **An emergency situation prevented us from obtaining acknowledgement**
- ⬭ **Other (please specify)**

Patient Financial Agreement

Shaista Najmi, DMD requires all patients to make financial arrangement with us before we provide treatment.

1. I understand for any appointment time exceeding one hour with Dr Najmi, that pre-payment of my patient portion (for patients with insurance) and full prepayment of service (for those that do not have dental insurance) will be necessary two days prior to the scheduled apptointment time to keep your scheduled appointment reserved.

2. I understand that it is solely my responsibility to confirm which treatment or procedures are covered by my insurance (including, but not limited to, any applicable exclusion, deductibles, and annual or lifetime maximums.

3. I understand that as a courtesy, Shaista Najmi, DMD will attempt to verify my insurance coverage from information that I provided and will file two claims per appointment. I am required to pay full, before treatment is performed, the estimated portion of any procedures or treatment that will not be covered by my insurance.

4. I understand that insurance claims will only be filed if I provide Shaista Najmi, DMD with my social security and insurance ID number (if applicable). If I choose not to provide Shaista Najmi, DMD with my social security number, I understand that I must pay in full for all services rendered. It is Shaista Najmi, DMD's policy to require social security numbers for recordkeeping purposes even though that may not be the policy of my insurance carrier.

5. I understand that the insurance estimated may differ from what my insurance carrier ultimately pays and that I am responsible for any amount not paid by my insurance for any reason.

6. I understand that if I discontinue treatment for a requested procedure, including but not limited to, partial, denture, crowns, bridgework and surgical preparatory work, I remain responsible for paying all lab related costs for materials and services that were incurred before I discontinued treatment. All Related costs will be deducted from any refund to which I may be entitled for discontinued treatment.

7. I understand that all account balance over 30 days will incur an interest charge at the maximum legal rate allowed.

8. I understand that I will be charged that maximum service charge allowed by law for any dishonored check, electronic concerning my treatment or charges.

9. I understand that I must timely inform Shaista Najmi, DMD, in writing, of any concerns questions or disputes I may have concerning treatment or charges.

10. I understand that if I fail to pay my account in a timely manner, Shaista Najmi, DMD may repost my account to credit rating bureaus & Send to collection agency with an additional 40% and/or take legal action against me for full payment, including but not limited to all related reasonable attorney's fees, collection and/or court costs.

_____ _____

Signature of Patient or Guardian Date

11. I understand that unless patient records are sent directly to a referred provider, the charge for copies of x-rays is $35.00 and treatment information is $5.00 or maximum amount allowed by law. These fees are subject to charge without notice.

12. I understand that Shaista Najmi, DMD currently may charge $50.00 for any broken or cancelled appointment and/or $100.00 for any broken or cancelled appointment with a specialist, if cancelled with less than 24 hour notice. This time has been specifically reserved for you. Please call at least 24 hours ahead of time if you must cancel an appointment. This fee is subject to charge without notice.

13. I understand that it is my responsibility to immediately notify Shaista Najmi, DMD of any change to my address, phone number, work contact information, work status, insurance changes, etc.

14. I authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity, I further authorize Shaista Najmi, DMD to deposit checks received on my account when made payable in my name.

15. I authorize my before and after cosmetic and restorative photos to be used as office comparisons, and educational purposes.

16. For the safety of our patient and staff we have 24 hour surveillance throughout the office.

I have thoroughly read, understand and agree to the above terms and conditions.

_____ _____

Signature of Patient or Guardian **Date**

**** Interest charges will accrue on balances that have not been paid on the 30th day after the billing date. Late payment fees and returned check fees, if any, are not included in the daily/monthly balance. The interest rate imposed be Shaista Najmi, DMD shall be 18% per annum or the highest rate permitted under the applicable law of Florida depending upon where patient treatment was preformed. Your payment to any outstanding balance may be allocated in a manner which Shaista Najmi, DMD determines and as legally allowed, and may change from time to time. Shaista Najmi, DMD reserves the right to apply payment to balances with lower interest rates.**