A+ DENTAL
SHAHNAZ BABALOUI, D.D.S.
GENERAL DENTISTRY
2661 MIDWAY RD. STE. 230
CARROLLTON, TX 75006
972-380-4300

Patient Information

Patient Name: _____ Date: _____
Last First MI (preferred name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security # _____ Birth Date: _____

Contact (Home): _____ (Cell): _____ (Email): _____

Address: _____
Street Apartment #

_____
City State Zip Code

In case of emergency, whom may we contact? _____ Phone: _____

Spouse or Responsible Party Information

The following is for: ☐ Same as patient ☐ The patient's spouse ☐ The person responsible for payment

Name: _____ Date: _____
Last First MI (preferred name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security # _____ Birth Date: _____

Contact (Home): _____ (Cell): _____ (Email): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Today's visit will be paid by: ☐ Cash ☐ Credit Card ☐ Debit Card

Responsible Party Signature: _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative ☐ Dental Insurance Co.

☐ Yellow pages ☐ Work ☐ Online/Google ☐ Other: _____

Name of person or office referring you to our practice: _____

Employment Information

The following is for the ☐ Patient ☐ Responsible Party

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Insurance Information

Insurance Company Name: _____

Assignment and Release:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____, and assign directly to Shahnaz Babaloui, D.D.S., 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 Dr. Shahnaz Babaloui, D.D.S., to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Date: _____

MEDICAL AND DENTAL INFORMATION

Have you ever had or have any of the following? Please check those that apply.

☐AIDS
☐Allergies
_____
_____
☐Anemia
☐Arthritis
☐Artificial Joints
☐Asthma
☐Blood Disease
☐Cancer
☐Diabetes
☐Dizziness
☐Epilepsy
☐Excessive Bleeding
☐Fainting
☐Glaucoma
☐Growths
☐Hay Fever
☐Head Injuries
☐ Heart Disease
☐Heart Murmur
☐Hepatitis
☐High Blood Pressure
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Mental Disorders
☐Nervous Disorders
☐Pacemaker
☐Pregnancy
Due Date: _____
☐Breast Feeding
☐Radiation
☐Respiratory Problems
☐Rheumatic Fever
☐Rheumatism
☐Sinus Problems
☐Stomach Problems
☐Stroke
☐Tuberculosis
☐Thyroid Disease
☐Tumors
☐Ulcers
☐Venereal Disease
☐Codeine Allergy
☐Penicillin Allergy
☐Other
_____
_____
Please list all medications that you are currently taking.

_____
_____
_____
_____
_____
_____

- Do you have pain in your jaw or near your ears? Y N
- Have you ever had nitrous oxide? Y N
- Do your gums bleed? Y N
- Do you have a bad taste in your mouth/odor? Y N
- Do you habitually clench/grind your teeth during The day or at night? Y N
- Is any part of your mouth sensitive to pressures Or irritants (hot, cold, sweets) Y N
- Do you use tobacco products? Y N

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctor at the next appointment without fail.

_____

Signature of patient, parent or guardian Date

Consent for Services

As a condition of your treatment by this office, the 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 muse be paid for in cash at the time services are performed. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.

All charges are your responsibility whether your insurance pays or does not pay. Not all services are a covered benefit. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. I understand that employees of A+ Dental are NOT representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company. If your insurance company does not pay in full within 45 days, we may require you to pay the balance. Balances older than 60 days may be subject to collection placement and fees. I understand the fee estimate listed for this dental care can only be extended for a period of six months from the date of patient examination.

In consideration for the professional services rendered to my, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (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's fees if suit were 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 payment and agree to their content.

_____ Date: _____ Relationship to patient:_____

Signature of patient, parent or guardian

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LETTER OF UNDERSTANDING OFFICE INSURANCE POLICY

Patient: _____ Date: _____

We are pleased that you have dental insurance coverage and we will be happy to assist you in using your benefit program. Our office staff understands your insurance coverage and will help you maximize the benefits allowed under your plan.

You must realize, however, that:

- Your dental benefits are a contract between YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. We are NOT a party to that contract.
- Our fees generally are NOT fully covered by the maximum allowance determined by your carrier.
- Not ALL dental services are covered by dental benefits.
- YOU are responsible for all fees incurred for services rendered to you.

Please discuss your proposed dental treatment with us and ask all necessary questions before you begin treatment.

Signature: _____
(Business personnel signature)

I understand and agree to abide by this policy.

Signature: _____ Date: _____

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APPOINTMENT CANCELLATION/NO-SHOW POLICY

It is necessary that we work by appointments. We take pride in our ability to honor the time reserved for you. If you cannot keep a scheduled appointment, we ask that you give 24 hours cancellation notice so that someone else may use your appointment time. Advance notice of cancellation consists of talking directly with a member of our staff. Voice mail messages do not give us enough time to allow another patient to use your promised time. If you call the same day of your appointment to reschedule, it will be considered a 'no-show'. We do understand that emergencies do occur and in the event of one, you will not be able to make it to your appointment. Therefore, we will allow 2 missed appointment. If you miss a 3rd appointment, you will be required to pay a $50.00 fee. This courtesy on your part will make it possible to give your appointment to another patient if needed.

I understand and abide by this policy.

_____

Patient Name

_____

Signature of patient, parent or guardian Date

_____

Signature of Business Personnel Date

****For Women Only****

Women are advised that antibiotics may interfere with the effectiveness of birth control pills. Other means of contraceptives are recommended when taking antibiotics.

I have been informed of the risks of antibiotics.

_____

Signature of patient Date

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COVID-19 PANDEMIC DENTAL TREATMENT
NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and stadd, and to advance the safety of our local community.

This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Dur to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in the dental office.

Dental procedures create water spray, which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment, as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting COVID-19 virus in the dental office or with dental treatment. I also acknowledge that I could contract the COVID-19 virus from outside this office and unrelated to my visit here.

I have read and understand the information stated above.

_____

Patient Name

_____

Patient/Guardian Signature Date

_____

Witness Signature

COVID-19 PANDEMIC- PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided are true and accurate.

_____

Signature Date

_____

Witness

Photography Release

I _____ hereby authorize Dr. Babaloui or her
(name)
assistants to take photographs, slides, and/or videos of my face jaws, mouth and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes, seminars, demonstrations and professional publications (journals, magazines).

I further understand that if the photographs, slides and/or videos are used in any publication or as part of a demonstration, my name and other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

_____

Signature Date

Oral Screening Consent Form

Complete each time the examination is performed and place in patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates or oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk:

- *patients ages 18-30*
- *Sexually active patients (HPV 16/18)*

High Risk:

- *Patients age 40 and older, tobacco users (any age, any type within 10 years)*

Highest Risk

- *Patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use)*
- *Previous history of oral cancer*

We have recently incorporated ViziLite® Plus into our oral screening standard of care. We find that using ViziLite® Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite® Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite® Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects or oral cancer and possibly save your life. The ViziLite® Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however this exam might not be covered by your insurance. The fee for this enhanced examination is $70.00.

Yes. I authorize the clinician to perform the ViziLite® Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.
Print name: _____
Signature: _____ Date: _____

No. I would prefer not to have the ViziLite® Plus exam at this time.
Print name: _____
Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient Legal Relationship to the Patient
(If required)

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ **I decline** to receive communications via **text.**

_____ **I decline** to receive communications via **email.**

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible