Shahnaz Babaloui, DDS • General Dentistry
2661 Midway Rd. #230 • Carrollton, TX 75006 • 972-380-4300

Patient Information

Patient Name: ______________________ **Date:** __________
Last First MI

◯ Male ◯ Female ◯ Married ◯ Single ◯ Child ◯ Other __________

SS#: __________ DOB: __________ Email: __________

Phone: (Home) __________ (Cell) __________ (Work) __________

Address: ______________________
Street Apt# City State Zip

In case of emergency, whom may we contact: ______________________
Name Phone

Spouse or Responsible Party Information

The following is for: ◯ Same as Patient ◯ The Patient's Spouse ◯ Person Responsible for Payment
◯ Male ◯ Female ◯ Married ◯ Single ◯ Child ◯ Other __________

Name: __________ SS#: __________ DOB: __________

Phone: (Home) __________ (Cell) __________ (Work) __________

Address: ______________________
Street Apt# City State Zip

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 ◯ Another patient, relative
◯ Dental insurance company ◯ Yellow pages ◯ Internet search ◯ Other __________

Name of person referring you to our practice __________

Employment Information

The following is for the: ◯ The Patient ◯ The person responsible for payment

Employer: __________ Occupation: __________

Insurance Information

Primary Dental Insurance Company:

Name: __________

Address __________

Phone #: __________

Policy #: __________ Group #: __________

Eff Date: __________

Subscriber: DOB: __________ SS#: __________

Assignment and Release

I, the undersigned certify that I (or my dependant) have insurance coverage with __________ and assign directly to Dr. Shanhnaz Babaloui, D.D.S., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finacially 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 the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: __________ Date: __________

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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
____
____

List of medications that you are currently taking
____
____
____
____
____
____

- Do you have pain in your jaw or near your ears? ◯ Yes ◯ No
- Have you ever had nitrous oxide? ◯ Yes ◯ No
- Do your gums bleed? ◯ Yes ◯ No
- Do you have a bad taste in your mouth, or mouth odor? ◯ Yes ◯ No
- Do you habitually clench or grind your teeth during the night or day? ◯ Yes ◯ No
- Is any part of your mouth sensitive to pressures or irritants (hot, cold, sweets) ◯ Yes ◯ No
- Do you use tobacco products? ◯ Yes ◯ No

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

____
Signature of patient, parent or guardian

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 performed without previous financial arrangements must 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 insurance 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 company 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 that the fee estimate listed for this dental care can only be extended for a period of six months from the date of exam. In consideration for the professional services rendered to me, 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 services are rendered, or within 5 days of billing, if credit is extended. I further agree that the reasonable value of said services shall be 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 suit were instituted hereunder.

I grant my 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.

____
Signature of patient, parent or guardian | Date | Relationship to Patient

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Complete each time the examination is performed and place in the 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 of 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 18-39*
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 or oral cancer*

We have incorporated ViziLite® Plus into our oral screening standard of care. We find that using ViziLite Plus along with the 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 earlies possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of 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 $50.

NO I would prefer not to have the ViziLite Plus exam at this time.

____

Print Name Signature Date

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

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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 us a 24 hour cancellation notice. In doing so, it will allow us to schedule someone else. 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', and you will be required to pay a $50 fee. This courtesy on your part will make it possible to give your appointment to another patient.

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 while taking antibiotics.

I have been informed of the risks of antibiotics.

____

Signature of Patient Date

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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 under 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.
- All dental services are NOT covered by 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 of Business Office Personnel

I understand and agree to abide by this policy.

____

Signature of Patient Date

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PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payors (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restriction.

I understand that I may revoke my consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Preference Regarding Communication of Health Information

Who To Contact

I hereby give permission to A+ Dental, Shahnaz Babaloui, DDS and Staff to disclose and discuss any information related to my medical/dental condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s):

_____________________________________ _____________________________________
Name Relationship

_____________________________________ _____________________________________
Name Relationship

_____________________________________ _____________________________________
Name Relationship

____ I do **NOT** wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical/dental condition(s).

How To Contact

I wish to be contacted in the following manner:

Home Telephone_____________________________ Work Telephone_____________________________

___ OK to leave a message with detailed information ___ OK to leave message with detailed information ___ Leave message with call back number only ___ Leave message with call back number only

____ ____
Print Patient Name Relationship to Patient