Y W C

Yousefi Washington Clinic

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New Patient Paperwork

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Yousefi Washington Clinic

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ABOUT YOU

Name _____ *Today's Date* _____

Date of Birth _____ *Social Security Number* _____

Address

_____

_____

Mobile Phone _____ *Home Phone* _____ *Work Phone* _____

Email _____ *Occupation* _____

Emergency Contact _____ *Emergency Contact Phone* _____

DENTAL INFORMATION: *Please mark each box with your response, use 'DK' if you don't know an answer.*

	Yes	No	DK
Are you currently experiencing any pain or discomfort?	☐	☐	■
Do your gums bleed when you brush or floss?	☐	☐	■
Are your teeth sensitive to cold, hot, sweets or pressure?	■	☐	☐
Is your mouth dry?	■	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	■
Have you ever had orthodontic (braces)treatment?	☐	■	☐
Have you had any problems associated with previous dental treatment?	☐	■	☐

	Yes	No	DK
Do you have earaches or neck pain?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux (grind) your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to yourhead or mouth?.	☐	☐	☐

*What was the date of your last dental exam (month and year)?*_____

What is the reason for your visit today?

_____

_____

_____

How do you feel about your smile?

_____

_____

Do you have dental insurance? If so, please provide the details below. Please also provide your card so we may make a copy.

Insurance Carrier _____ *ID Number* _____ *Group Number* _____

Subscriber Name _____ *Subscriber Birthday* _____

MEDICAL INFORMATION: *Please mark each box with your response, use 'DK' if you don't know an answer.*

Are you under the care of a physician?

Physician Name: _____ *Physician Phone Number:* _____

Yes No DK

Have you had a serious illness, operation or have been hospitalized in the past 5 years? ☐ ☐ ☐

If yes, what was the problem: _____

Yes No DK

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐

Date: _____

If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐

Date Treatment began: _____

Allergies: Are you allergic to or have you had a reaction to:

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbituates, sedatives or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐

Other: _____

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐

If so, how interested are you in stopping?

☐ Very ☐ Somewhat ☐ Not Interested

	Yes	No	DK
Do you drink alcoholic beverages?	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours: _____

If yes, how much do you typically drink in a week?

_____

WOMEN ONLY: Are you:

	Yes	No	DK
Pregnant?	☐	☐	☐

Number of weeks: _____

	Yes	No	DK
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Yes No DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of the physician or dentist making the recommendation: *Phone Number:*

_____ _____

List any medications you are currently taking:

_____

_____

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MEDICAL INFORMATION: *Please mark each box with your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital Heart Disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV Infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systematic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐

	Yes	No	DK
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
GE Reflux/persistent heart burn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
If yes, specify: _____			
Recurrent infections	☐	☐	☐
Type of infections: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	■
Sexually transmitted disease	☐	■	☐
Excessive urination	☐	■	☐

Please list any other disease, condition or problem not listed about that you think we should know about?

_____

_____

Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information give on this form is accurate. I understand the importance of a truthful health history and that my dentist and the staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff, responsible for any action they take or do not take because of errors or omissions that I may have made I the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

OFFICE POLICY

RADIOGRAPHS (X-RAYS)

Part of the comprehensive exam will include radiographs; these are necessary so that the doctor can fully understand what is happening inside your mouth. If you have radiographs from a previous doctor and wish to provide them and we will gladly review them to understand if they are recent, adequate and diagnostic. If the radiographs do not meet these criteria or we do not have them before the appointment, then the new ones will be taken. If you are unable to provide radiographs that meet these criteria and refuse new radiographs, we cannot perform the exam and we cannot accept you as a patient until radiographs are taken. We update bitewing x-rays and periapical x-rays once a year and panoramic x-ray every 3 years for our existing patients.
Initial: _____

MOBILE DEVICE POLICY

In order to comply with Federal Law and the Health Insurance Portability and Accountability Act (HIPAA) mobile devices are prohibited from use in the clinical areas of the office. It is prohibited to take any photos or videos while in the office. It is prohibited to send any information about another patient (via social media, text, email, voice, etc.). We apologize for any inconvenience this may cause and appreciate your cooperation in this matter.
Initial: _____

BROKEN APPOINTMENTS

In order to serve you better, we try to maintain an efficient appointment system. Our cost of providing quality care increases greatly when patients fail to keep scheduled appointments or cancel at the last minute. As a courtesy, we will call, text, and email you, to remind you of your appointment. Please call, leave voicemail or email us to confirm your appointment 2 business days before, as appointments will be canceled 24 hours before if unconfirmed. Please notify us at least 2 business days in advance if you are unable to keep your scheduled appointment. After the second broken appointment, a charge of $50 will be applied to your account if we are not notified in advance. After 3 missed or cancelled appointments, we will place you on an executive call list. This means that you cannot schedule in advance and we will phone you when an appointment time becomes available on short notice.
Initial: _____

RESERVING APPOINTMENTS

Pre-payment is required to reserve appointments other than regular cleanings and periodontal maintenance. You will be required to pay 50% of your copayment/ coinsurance at the time of scheduling. Collecting in advance allows our office to reserve your time with the doctor. When you prepay for treatment, you are agreeing to take care of your dental needs. We have several payment methods we offer to our patients to assist them in taking care of their dental needs. A $35.00 fee will be applied for any returned checks.
Initial: _____

TREATMENT ESTIMATES

This office routinely provides our patients with an estimate of cost for dental treatment/ and or procedures prior to rendering services. If you are using dental insurance, a pre-treatment estimate may need to be submitted to your insurance company to determine the schedule of benefits for the services to be rendered. Pretreatment estimates may not always be accurate, and your insurance ultimately determines the benefits payable for service after treatment has been completed and claims have been submitted and processed. **Initial: _____**

FINANCIAL AGREEMENT

Yousefi Washington Clinic will gladly aid you in filing your insurance. Remember that your co-payment (the portion that is not covered by your insurance) and your yearly deductible is due at the time of service. Please be aware that your insurance is a contract between you and your insurance company, and we are not a party to that contract. **It is your responsibility to make sure that you are covered at the time of service**. If for any reason your insurance company does not cover a procedure or denies your total charges, **it is ultimately your responsibility to pay for the services.** If your insurance company has not made payments within 50 days from date of service, the balance will become your responsibility. Accounts unpaid after 50 days from day of service are subject to a delinquent fee of $35.00. Furthermore, the unpaid balance is subject to a 1.5% monthly (18% Annual) finance charge. If we must submit your unpaid account to a collection process you will be responsible for all charges our practice incurs; including collection fees, court costs and reasonable attorney's fees. Any dental service performed without financial arrangements, must be paid in full at the time of service. **Initial: _____**

Yousefi Washington Clinic reserves the right to update this Office Policy at any time without notification. Your signature verifies that you have read, understood, and accepted the policies described above, and further grants Yousefi Washington Clinic permission to telephone you at home or at work to discuss matters related to this form.
I have carefully read and agree to these terms and conditions:

_____
Print Name of Patient or Guardian of Minor Patient

_____ _____
Signature of Patient or Guardian of Minor Patient Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 to sign this Consent. Our Notice provides a description of our treatment, payment activities, 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.

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 Contract 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.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I acknowledge that I have received this office's Notice of Privacy Practice and 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 healthcare operations.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Revocations of Consent
(Please read and sign below ONLY if you choose NOT to sign above)

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I acknowledge that I have received this office's Notice of Privacy Practices and I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation.
I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____