URGENT FAMILY DENTISTRY

Welcome to Urgent Family Dentistry

Dr. Hamdan, DDS, MS

2520 K Avenue Suite 180

Office: 972-423-1234 Fax: 972-424-6543

Urgentfamilydentistry.com urgentfamilydentistry@gmail.com

PATIENT INFORMATION

Patient Name:_____ Birth Date:_____ Age:_____ Gender:_____

SS #: _____ Address: _____

City:_____ State:_____ Zip:_____ Home Phone:_____

Work:_____ Cell:_____ Email:_____

Employer: _____

How did you hear about us? _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____ Insured's Birth Date: _____

Subscriber ID #: _____ SS #: _____ Relationship to patient: _____

Insured's Employer Name: _____

Insurance Company: _____ Group Number: _____

Phone: _____ Insurance Claims Mailing Address: _____

Please describe the main reason for your appointment. (How long has this issue been going on & what other past events apply?)
Explain: _____

What and Where is closest pharmacy located? _____

When was your last Dental Examination? _____ **Cleaning?** _____ **X-Rays?** _____

Current Home Care: Tooth Brush: Manual or Electric How **often?** _____ **Floss:** Daily Occasionally Rarely

HAVE YOU EXPERIENCED TROUBLE WITH (check all that apply):

- ○ Thyroid
- ○ Gag Reflex
- ○ Joint Replacement
- ○ Trouble Swallowing
- ○ Herpes
- ○ Shingles
- ○ HIV/Aids
- ○ Hepatitis
- ○ Appendix
- ○ Gall Bladder
- ○ Bad Breath
- ○ Ulcers/Blisters
- ○ Headaches/Migraines
- ○ Kidney problems
- ○ Dry Mouth
- ○ Diabetes
- ○ Epilepsy/Seizures
- ○ Stroke
- ○ Arthritis
- ○ Fatigue
- ○ Dizzy Spells
- ○ Swollen Lymph nodes
- ○ Poor Memory
- ○ Hair Loss
- ○ Mood Swings
- ○ Irritability
- ○ Foggy Thinking
- ○ Anxiety
- ○ Fatigue
- ○ Elevated Cholesterol
- ○ Heart Palpitations
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Heart Murmur
- ○ Heart Attack
- ○ Swollen Extremities
- ○ Chest Pain/Pressure
- ○ Abnormal Bleeding
- ○ Anemia
- ○ Rheumatic Fever
- ○ Congenital Heart Defect
- ○ Down Syndrome
- ○ Pacemaker/Artificial Valve
- ○ Mitral Valve Prolapse
- ○ Bronchitis
- ○ Pneumonia
- ○ Asthma
- ○ Lung Disease
- ○ Blood Transfusion
- ○ Depression
- ○ Cancer
- ○ Chemo Treatments
- ○ Latex Allergy
- ○ Metal Allergy
- ○ Ehlers-Danlos Syndrome
- ○ Penicillin Allergy
- ○ Sulfa Drug Allergy
- ○ Codeine Allergy
- ○ Alcoholism
- ○ Drug Abuse
- ○ Heart disease
- ○ HPV
- ○ Hemophilia
- ○ Aspirin Allergy
- ○ Food Allergies (please list below)
- ○ Sinus Trouble

Other: _____

Please List Any Known Allergies and/or Drug Allergies:

WOMEN ONLY

Is there a chance you may be pregnant? Yes No

Are you currently nursing? Yes No

Are you taking any oral contraceptives? Yes No

Have you had a Hysterectomy? Yes No

LIST MEDICATIONS (Rx & Over-the-counter, Dosage, Frequency):

_____

_____

_____

PLEASE LIST ALL SURGERIES/INJURIES & DATE:

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been completed accurately. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN ***DATE***

URGENT FAMILY DENTISTRY

LIMITATION OF INSURANCE COVERAGE and PAYMENT

We realize how complex and confusing dental insurance can be. We would like to highlight a common misconception - dental insurance was ***not designed to pay for all dental care***. All Insurance contracts have limitations, alternate benefits and/or various degrees of co-payment. The benefits you receive are based on the contract ***between you or your employer and the dental insurance company***, not our office. Some services you may need or want may not be covered by your insurance benefit plan. ***The treatment plans are based on an estimate and fees provided by your insurance company*** and are subject their review. There are no guarantees of coverage. Our goal is to help you achieve and maintain optimal dental care and we will not compromise your care based on restraints of an insurance company.

As a courtesy, Urgent Family Dentistry will file all claims based on your PPO dental insurance plan. All Applicable deductibles, co-insurance amounts, and non-covered services amounts are due at the time service is rendered. You will be required to pay for your visit in full at the time of service if you are unable to provide the current insurance information before your scheduled appointment.

All estimated payments are collected before you are seen by the doctor and any adjustments that need to be made can be made at the end of your visit, and any final bill and/or credit will be issued once payment from your insurance company has been received. Cash, Master Card, Visa, Discover, and Care Credit are all acceptable forms of payment in our office. Picture ID is required in conjunction with all forms of payment except cash.

We do not offer long term in-house financing; however, we have partnered with Care Credit which offers several short term no-interest and long-term payment plans with minimal interest. You can apply for Care Credit in our office with the assistance of a staff member or online at www.carecredit.com.

I have received and understand the financial policy of Urgent Family Dentistry; I also hereby give Urgent Family Dentistry permission to file claims with my insurance company on my behalf.

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN ***DATE***

URGENT FAMILY DENTISTRY

Missed Appointment and Late Cancellation Policy

A missed dental appointment presents problems for us both. For you, a missed dental appointment causes a delay in treatment that was recommended to help improve your dental health.

For our office, a missed dental appointment prevents us from scheduling another patient that could benefit from treatment. ***We schedule individual time with each patient*** to allow us to deliver the quality and personal care that every patient deserves.

Our office policy is that we charge $25 to $100 for a missed appointment, late cancellation, or for failed appointments. The charge is based on the length reserved for your appointment.

We understand that things happen and schedules do change. We do always call a day before to confirm your appointment, we ask that you provide us with at least 24-hour notice for any appointment changes. Failure to provide at least a 24-hour notice for changed appointments will result in a fee and/or automatic cancellation of your appointment.

We do ask if you are to arrive late to your appointment to please call us in advance, we do schedule appointments based on our doctor's availability. **Any arrivals 15 minutes after the scheduled time will have to be rescheduled for a different day.** Arriving late to such appointment does put your dental treatment and others behind. We kindly do ask the scheduled time is respected.

We value and appreciate you as a patient and look forward to seeing you for future appointments.

Thank you,

Urgent Family Dentistry
Dr. Hamdan, DDS, MS

Patient Name (Print): _____

Print Parent/Guardian Name: _____

Patient/Guardian Signature:_____Date: _____

URGENT FAMILY DENTISTRY

INFORMED CONSENT FOR DENTAL EXAM, X-RAYS, MEDICATIONS, CHANGES IN TREATMENT PLAN, PROPHYLAXIS, FLUORIDE TREATMENT, AND ANESTHESIA.

Patient's Name: _____

DENTAL EXAMINATION AND X-RAYS

I understand that regular dental exams and x-rays are needed to complete the examination diagnosis and treatment plan. X-rays are an important diagnostic tool for the dentist. Many diseases of the teeth and surrounding tissues cannot be seen visually. An x-ray may reveal the presence of caries between the teeth, infections in the bone, abscesses, cysts, and other items that cannot be seen visually. Risks from radiation exposure have been significantly reduced by improvements in technology. I understand if I choose not to allow x-rays to be taken, the dentist cannot formulate an accurate diagnosis and treatment plan.

MEDICATIONS

Initial _____

I have been informed and understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the dentist of any known allergies. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills).

CHANGES IN TREATMENT PLAN

Initial _____

I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination (the most common being root canal therapy following routine restorative procedures). I give my dentist permission to make any/all changes and additions as necessary.

PROPHYLAXIS (CLEANING) AND FLUORIDE TREATMENT

Initials _____

Regular dental prophylaxis plays an important role in proper dental health. Prophylaxis includes removal of soft and hard deposits on teeth, and teeth polishing with prophy paste. Risks include, but not limited to, sensitivity or bleeding of the teeth or gums. Fluoride is applied topically as a gel or paste. Fluoride helps prevent tooth caries by making teeth stronger and is considered safe when properly used. Ingestion of high concentration can lead to nausea and/or vomiting.

LOCAL ANESTHETICS

Initials _____

I understand that the administration of local anesthetic may cause an adverse reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, muscle soreness, and temporary, or permanent, numbness. I understand that occasionally needles break and may require surgical removal.

Initials _____

I understand that dentistry is not an exact science; therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and to ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment plan.

_____ _____

Patient's or Legal Guardian Signature — Date

_____ _____

Witness to Patient's Signature — Date

_____ _____

RDA — Date

Dr. Hamdan/Dr. Er/ Dr. Reza _____, DDS certify that I have explained to the above patient the ramifications of the treatment initialed by the patient to the best of my professional ability. I further certify that in my opinion, the above patient is fully informed of the risks and possible benefits of the particular procedure agreed upon.

URGENT FAMILY DENTISTRY

Please answer the following questions:

1. Have you returned from any of these countries in the last 14 days?

Yes___ No___

China

Iran

South Korea

Italy

Japan

Outside of Texas

If the answer is yes where did you travel to? _____

2. Have you had close contact with anyone with or cared for someone diagnosed with COVID-19 within the last 14 days?

Yes____ No____

3. Have you experienced any cold or flu-like symptoms in the last 14 days (to include fever, cough, sore throat, respiratory illness, or difficulty breathing)?

Yes _____ No____

If you answered yes to question 1 and-or 2-3, please call your primary care provider or your State Department of Health for further direction.

If your answer is "yes" to any of the questions, access to the facility will be denied.

Patient Name: _____

Signature: _____ Date:_____

URGENT FAMILY DENTISTRY

HIPPA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FOR RECIEPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy for this healthcare facility. A Copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Please *print* name of Patient Please *sign* Patient / Legal Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

[ ] First Name Only [ ] Proper Surname [ ] Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTHCARE AND WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION: (This includes step parents, grandparents, and any care takers who can have access to this patient's record.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:**

- ○ Cell Phone Confirmation
- ○ Home Phone Confirmation
- ○ Email Confirmation
- ○ Any of the above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ○ Cell Phone Confirmation
- ○ Home Phone Confirmation
- ○ Email Confirmation
- ○ Any of the above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- ○ Cell Phone
- ○ Email
- ○ Any of the above
- ○ None of the above (OPT OUT)

In signing this HIPPA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your health. This office may or may not receive third party remuneration from these companies. We under current HIPPA Omnibus Rule provide you this information with your knowledge and consent.

OFFICE USE ONLY

As a privacy officer, I attempted to obtain patient's or representative signature on this Acknowledgment but did not because:

[ ] It was emergency treatment [ ] I could not communicate with the patient [ ] The patient refused to sign [ ] Other _____

Privacy Officer Signature: _____