PATIENT INFORMATION FORM

Date: _____ Date of Birth: _____ ☐ Male ☐ Female

Name: _____ Social Security #: _____

Address: _____ Email: _____

Apt. _____ Home Phone: _____

City _____ State ____ Zip _____ Cell Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Business Name: _____ Bus. Phone: _____

Position or Occupation: _____ Referred By: _____

Dentist Name: _____ Phone: _____

Address: _____

Physician Name: _____ Phone: _____

Emergency Contact Person's Name and Number _____

MEDICAL HISTORY

(Check if you have ever had the following)

- ☐ PROSTHETIC CARDIAC VALVES
- ☐ RHEUMATIC FEVER
- ☐ HEART MURMUR
- ☐ HIGH BLOOD PRESSURE
- ☐ JOINT PROSTHESIS (HIP, KNEE, ETC.)
- ☐ ARTHRITIS
- ☐ KIDNEY CONDITION
- ☐ LIVER CONDITION
- ☐ THYROID CONDITION
- ☐ ASTHMA
- ☐ TUBERCULOSIS
- ☐ SHORT OF BREATH
- ☐ LUNG PROBLEM
- ☐ REACTION TO CODEINE
- ☐ REACTION TO LATEX
- ☐ REACTION TO NICKEL OR CHROMIUM
- ☐ REACTION TO PENICILLIN
- ☐ REACTION TO OTHER DRUGS
- ☐ REACTION TO LOCAL ANESTHESIA
- ☐ REACTION TO BLEACH
- ☐ CORTISONE THERAPY
- ☐ BLOOD DISEASE (ANEMIA)
- ☐ HEPATITIS
- ☐ GLAUCOMA
- ☐ DIABETES
- ☐ SEIZURES, EPILEPSY
- ☐ SINUS PROBLEMS
- ☐ STOMACH ULCERS, COLITIS
- ☐ CANCER OR CANCER TREATMENT
- ☐ PROLONGED BLEEDING
- ☐ PACEMAKER
- ☐ VIRAL INFECTIONS
- ☐ PURPLISH OR REDDISH AREAS ON SKIN OR IN MOUTH
- ☐ TMJ PROBLEMS
- ☐ PSYCHIATRIC TREATMENT
- ☐ PERSISTENT OR SEVERE HEADACHES &/OR MOOD CHANGES
- ☐ HAVE YOU LOST WEIGHT RECENTLY WITHOUT TRYING?
- ☐ DO YOU HAVE HIV OR AIDS?

	YES	NO	IF YES, PLEASE LIST BELOW
Heart Conditions?	☐	☐	
Taking Medication?	☐	☐	
Allergies?	☐	☐	
Are you required to take antibiotics prior to dental treatment?	☐	☐	
Have you ever been admitted to a hospital?	☐	☐	
Have you ever had a root canal treatment?	☐	☐	
Are you presently under the care of a physician?	☐	☐	
Are you pregnant or nursing?	☐	☐	
Do you take birth control pills? (If yes, be advised that if you take antibiotics an alternative method of birth control must be used.)	☐	☐	
Does your occupation place you in a position of contact with whole blood or blood products? (clotting factors, cells, etc.)	☐	☐	
Are you currently taking or have you previously taken bisphosphonate medications such as Actonel®, Fosamax® or Zometa® within the past 12 years?	☐	☐	

ONLY ROOT CANAL THERAPY WILL BE PERFORMED AT THIS OFFICE. THE PERMANENT RESTORATION (FILLING, CROWNING, ETC.) WILL BE DONE BY YOUR REGULAR DENTIST.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND GIVE CONSENT FOR THE DOCTOR AND STAFF TO PERFORM THE NECESSARY DENTAL TREATMENT IF NEEDED AFTER THE EXAMINATION ON ME OR MY CHILD.

_____

Signature

Consent for Endodontic Treatment

The doctor has explained to me that there are certain **inherent and potential** risks in any treatment plan or procedure. Many factors contribute to the success of root canal treatment and cannot be determined in advance. Therefore, in some cases treatment may have to be discontinued before it is completed, or may fail following treatment. Some of these factors are: my resistance to infection, calcifications, location and shape of the canals. Sometimes other procedures may be needed to save the tooth: including **apical surgery**, crown lengthening surgery or it may need to be extracted.

I understand that the following may be inherent or potential risks for the treatment I will receive: Swelling; sensitivity bleeding; pain; **persistent or recurrent infection**; **numbness (paresthesia) and/or tingling** sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is usually transient but on the infrequent occasions may be permanent; reactions to injections; changes in occlusion (biting); jaw muscle cramps and spasm, temporomandibular joint difficulty (such as trismus); loosening of teeth, existing crowns or bridges; **damage of existing restorations**; referred pain to ear, neck and head; **delayed healing**; sinus perforations and **sinus infection**; treatment failure; complications resulting from the use of dental instruments **(broken instruments), perforations of the root** canal due to curved roots or existing conditions (such as **calcification**), medications, anesthetics and injections; discoloration of the face; **adverse reactions** to medications, anesthetics and injections causing drowsiness and lack of coordination. **Antibiotics may inhibit the effectiveness of birth control pills**. Premature tooth loss which may result from existing cracks or fractures and ones that may occur during or after the root canal treatment or from progressive periodontal disease. **Allergic reactions** to antibiotics or anesthesia or other medications/materials used in the office may take place. I also understand that, with respect to a root canal, the tooth is in a weakened state compared to a natural tooth. That makes the tooth subject to fracturing, or breaking. I also understand that a tooth, which has had a root canal, is still at risk for further decay and even infection.

I acknowledge that **no guarantees or assurances have been given** by anyone as to the results that may be obtained. I have been given the **opportunity to question the doctor** concerning the nature of treatment, the risks of the treatment and the alternatives to this treatment. **I understand that by doing nothing I run the risk of developing a severe infection, and losing a tooth.**

I have been told that success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication, reporting to the office any change in my health status, and returning to my General Dentist for permanent restoration.

Date:_____

Patient:_____ Dentist:_____ Witness:_____

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [x] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [ ] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender	8. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

9. Plan/Group Number	10. Patient's Relationship to Person named in #5
	[ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender	15. Policyholder/Subscriber ID (SSN or ID#)
	[ ] M [ ] F	

16. Plan/Group Number	17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above	19. Reserved For Future Use
[ ] Self [ ] Spouse [ ] Dependent Child [ ] Other	

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender	23. Patient ID/Account # (Assigned by Dentist)
	[ ] M [ ] F	

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier [ ] (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A")
A _____ C _____
B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Michael Baharestani DDS PC
12 Bond Street
Great Neck N.Y. 11021

49. NPI	50. License Number	51. SSN or TIN

52. Phone Number 516 829-4010 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment [11] (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics?
[x] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining	43. Replacement of Prosthesis	44. Date of Prior Placement (MM/DD/CCYY)
	[ ] No [ ] Yes (Complete 44)	

45. Treatment Resulting from
[ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number

56. Address, City, State, Zip Code	56a. Provider Specialty Code
Same	

57. Phone Number ( ) -	58. Additional Provider ID

Michael Baharestani D.D.S. PC

FINANCIAL POLICY - PLEASE READ THOROUGHLY AND INITIAL THE HIGHLIGHTED AREAS! We realize that every persons financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. However, **WE CANNOT GUARANTEE ANY ESTIMATED COVERAGE.** Because the insurance policy is an agreement between you and the insurance company, **YOU** are directly responsible for all charges. Please know that we will do everything possible to see that you receive the maximum benefits from your policy.

If, for some reason, your insurance company has not paid their portion within 30 days from the filing of the claim, you are responsible for payment at that time. **IT IS YOUR RESPONSIBILITY TO FOLLOW-UP WITH THE INSURANCE COMPANY REGARDING NONPAYMENT OF YOUR CLAIM**

_____ All office visits or diagnostic fees are to be paid **in full** at this office If you do not have dental insurance, payment is expected **in full** at time of treatment. We can make financing arrangements with you ahead of time.

_____ For participating insurances (those insurances in which this office has agreed to accept that company's payment rates), the **applicable co-payment is to be paid at the of treatment. This co-payment is only an estimate; your actual share may vary.**

OTHER FEES

_____**NO SHOWS** -Our office confirms all treatment appointments in advance. If you confirm an appointment, and then do not come at your scheduled time, or cancel without giving 24 hour notification, you will be assessed an $85 charge. Your insurance will not cover this fee.

PARTIAL TREATMENT - If you begin endodontic therapy and then decide on your own not to complete treatment, you are responsible for the appropriate half-treatment fee, and all subsequent possible oral health complications.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE. I HEREBY AUTHORIZE THE ABOVE NAMED ENDODONTIST TO FILE INSURANCE ON MY BEHALF AND AUTHORIZE PAYMENT DIRECTLY TO HIM FOR THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I AM AWARE THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY.

_____

PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name:_____ **Date of Birth:**_____

I have received this practice's Notice of Privacy Practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

· A statement that this practice is required by law to maintain the privacy of protected health information.

· A statement that this practice is required to abide by the terms of the notice currently in effect.

· Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.

· A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.

· A description of uses and disclosures that are prohibited or materially limited by law.

· A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

· My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

o The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliotory actions will be used againts me in the event of such a complaint.

o The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.

o The right to receive confidential communications of protected health information.

o The right to inspect and copy protected health information.

o The right to amend protected health information.

o The right to receive an accounting of disclosures of protected health information.

o The right to obtain a paper copy of the Notice of Privacy Practice from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practice and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's currect Notice of Privacy on request.

_____

_____

Signature Date