*Dear Patient,*

*Welcome to our practice. My staff and I are pleased that you have chosen us to provide your dental care and look forward to meeting you soon.*

*Please take a few minutes to familiarize yourself with our office policy and complete the Health History enclosed.*

## *Office Policy*

*Please arrive on time for your appointment.*

*Please give us a 48 hours notice if you are unable to keep a scheduled appointment. Occasionally, a patient will call with a dental emergency and we appreciate knowing that our time can be available to accommodate a patient in need. (Lack of notice can result in a missed appointment fee.)*

*If you have had any dental x-rays within the past 6 to 12 months please have them transferred to our office or bring them with you. Otherwise we can take the necessary x-rays in our office.* ***X-rays are needed for a complete exam or consultation.***

*If you are taking any medicine please provide us with an accurate list of drug names and regimens you are taking. If you need to be premedicated prior to dental procedures please have proper medical documentation for the reason for premedication (e.g., heart murmur).*

### *Payment Policy*

*A treatment plan and cost will be presented to you prior to start of treatment. We will estimate the percentage of treatment cost that should be covered by your insurance and inform you of the* ***estimated*** *patient share (aka copay). We will bill your insurance for their portion while your* ***estimated share/copay is due at the time of service.***

*Please feel free to always ask questions. You are important to us and we want you to be an informed dental partner. We look forward to meeting you soon!*

*Sincerely,*

*Dr. Chammas and Staff.*

**Tony G. Chammas, D.M.D.**
*Cosmetic Prosthodontics & Implant Dentistry*
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**Patient and/or Insured Authorization for "Signature on File"**
**(Release of information/financial responsibility/authorization for payment)**

**Cancellation Policy**

Please read carefully, sign and return to our office:

I _____ hereby authorize the office of Dr. Tony Chammas, A Professional Dental Corporation to affix my name to any and all claims or documents related to any and all health benefits due to me.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the dental office of Dr. Tony Chammas. I agree to be responsible for all charges for dental services not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize the release of any information related to a claim.

- As a patient with insurance benefits, you are responsible for payment for all services rendered according to the list of surcharges set by your dental insurance. Fees for services are paid at the time the services are rendered.

- We believe patients should know fees for the proposed services prior to the start of treatment. Although fees are given with every treatment plan, they are subject to change at anytime for any such reasons: Changes in treatment plan due to unexpected circumstances, insurance underpayments on elective treatments or upgrades, or outright denial of claims. Under the above circumstances and also those that may not be listed here, you will be responsible for any remaining balance and are expected to pay-in-full (Cash, Check, Visa, Master Card).

**Cancellation Policy:**

In consideration to the many patients awaiting treatment, appointments missed or cancelled without prior notification of two full working days (48 hours—Saturday and Sunday do not count) **will result in a charge of $50.00 added to your account**. This charge is to be paid before any future appointments are made and prior to continuing treatment unless otherwise agreed on with Dr. Tony Chammas and/or his staff.

This "Signature on File" will be valid from this date. A photocopy of this document may act as an original. Please feel free to ask any questions concerning any part of this document.

_____ _____

Signature of Patient or Guardian Date

**PATIENT INFORMATION AND HEALTH HISTORY**

***Please complete **BOTH SIDES** of this form***

Name: _____ Birthdate: ____-____-_____Prefer to be called:_____

Home Address: _____ _____City: _____Zip code:_____

Home Phone: _____Cell Phone: _____Work Phone: _____ Occupation: _____

Employer (parent if minor): _____City: _____

Social Security #: _____- ____ - _____ **E-mail:** _____

Other Family Members: (Spouse)_____ Age: ___ Name: _____Age: ___
Name: _____ Age: ___ Name: _____Age: ___

**DENTAL INSURANCE?** Yes __No __ Carrier _____Policy # _____
Insured Person's Name? _____ Employer: _____
Insured Person's social security #_____ - _____ - _____ Birthdate: _____

If MINOR, financially responsible party: _____

If EMERGENCY, contact: _____ Phone: _____- _____-____ Relationship: _____

**Whom may we thank for referring you to our office**? ----------

**REVIEW OF CHIEF CONCERN**

- Why are you seeking dental care at this time? _____
- Description of chief concern (onset, duration, intensity, frequency, etc.):_____
  _____
- Do you have any other pain or discomfort in your teeth : hot ___ cold ___ sweets ____ chewing_____
  Location: _____

**Areas you'd like more information on**:

Cosmetic Dentistry__ Prosthodontics _____ Implants _____ Veneers_____ Bleaching____
Gum Disease_____ Dentures_____ White fillings____ Amalgam/Mercury fillings___ Other _____

**DENTAL HISTORY**

Former Dentist: _____ City: _____
Were you satisfied? Yes_____ NO_____ Why? _____
Date of last visit _____ Services rendered: _____
Date of last x-rays:_____ Last cleaning? _____ How often do you have your teeth cleaned? _____

**How are you caring for your mouth? Brush ____x-day Floss? Yes____ No ____**

**Toothpaste:** _____ **Mouthwash or rinse?** _____ **Other** _____

**DO YOUR GUMS BLEED WHILE BRUSHING? Yes_____ No _____**

How many soft drinks you drink each day? ____ How often? ____ Cups of coffee or tea? ___ Sugar? ____

**If you could change anything about your teeth/smile, what would it be**? _____

**MEDICAL HISTORY**

Physician's name_____ Phone: _____
Are you in good health? (circle) excellent good fair poor
Are you currently receiving any medical care? Yes_____ No _____Describe _____

Have you been hospitalized or had a serious illness within the past 5 years? _____
Have you taken any medicine or drugs in the last two years? **Please list those drugs**: _____

Have you ever taken Phen Fen? Yes____ No_____

**Are you currently taking any medicine** (including over-the-counter medicine, vitamins, food supplements)?
_____

**BONE MEDICATIONS:**
**Have you received or are you currently taking medication known as bisphosphonates** (for example zoledronic acid **[Zometa],** pamidronate **[Aredia],** alendronate **[Fosamax],** or ibandronate **[Boniva]?** _____
Have you noticed any changes in your mouth, jaw, or felt any jaw pain or toothache since you have been on bone medication? _____

**ALLERGIES:** Are you allergic or have had a reaction to: Penicillin □_____Codeine□_____ **LATEX:** _____
Local injected anesthetics□_____ Other medications □_____Please describe_____

**Do you smoke**? Yes ___ No ____ How much per day? _____ # of years? _____
**Do you drink alcohol**? Yes ____ No _____ How much a day? _____

Circle Yes or No for any of the following which you had or have at present:

| | | |
|---|---|---|
| Yes / No Heart Disease or Attack | Yes / No Asthma | Yes / No Liver Disease |
| Yes / No Heart failure | Yes / No Hay fever | Yes / No Yellow Jaundice |
| Yes / No Angina / Chest pain | Yes / No Sinus Trouble | Yes / No Blood Transfusion |
| Yes / No High blood pressure | Yes / No Allergies or Hives | Yes / No Drug Addiction |
| Yes / No Heart murmur | Yes / No Diabetes | Yes / No Alcohol Addiction |
| Yes / No Mitral Valve Prolapse | Yes / No Thyroid Disease | Yes / No HIV Positive |
| Yes / No Rheumatic Fever | Yes / No X-ray or Cobalt Treatment | Yes / No AIDS |
| Yes / No Congenital Heart Disease | Yes /No Chemotherapy(cancer/leukemia) | Yes / No Hemophilia |
| Yes / No Scarlet Fever | Yes / No Arthritis | Yes / No Venereal Disease |
| Yes / No Artificial Heart Valve | Yes / No Rheumatism | Yes / No Cold Sores/Fever Blisters |
| Yes / No Heart Pacemaker | Yes / No Lupus | Yes / No Epilepsy or seizures |
| Yes / No Heart Surgery | Yes / No Cortisone Medicine | Yes / No Fainting or Dizziness |
| Yes / No Stroke | Yes / No Glaucoma | Yes / No Nervousness |
| Yes / No Kidney Trouble | Yes / No Pain in jaw joints/ TMJ | Yes / No Psychiatric Treatment |
| Yes / No Ulcers | Yes / No Artificial Joints ( hip, Knee) | Yes / No Sickle Cell Disease |
| Yes / No Emphysema | Yes / No Hepatitis A ( infections) | Yes / No Bruise Easily |
| Yes / No Cough | Yes / No Hepatitis B ( Serum ) | Yes / No Anemia |
| Yes / No Tuberculosis | Yes / No Hepatitis C | Yes / No **PREGNANT** |

Do you have any disease, condition, or problem not listed? _____

**CONSENT (Please Sign Each Paragraph)**:

- I authorize the doctor and dental assistant to take x-rays, impressions, photographs, or any other diagnostic aids to make thorough dental diagnosis. These diagnostic aids will be used to formulate treatment plans, to discuss with other doctors, and/or for educational purposes_____.

- I will then authorize doctor to perform dental treatment, medication (including local anesthetic injections), and therapy as explained to me in advance._____.

- I understand there are possible risks and complications associated with the administration of local anesthetics and drugs (such as swelling, bleeding, pain, nausea, bruising, tingling, allergic reactions, hematoma (swelling or bleeding near the injection site), fainting, lip or cardiovascular collapse, coma, or death). _____.

- I understand that responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time the services are rendered _____

Signature: _____Relationship to patient:_____ Date:_____

{Office of Dr. Tony Chammas – Cosmetic Prosthodontics & Implant Dentistry}

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____



**This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).**