WE WOULD LIKE TO TAKE THIS OPPORTUNITY TO WELCOME YOU TO OUR PRACTICE!!

Here at Dental Day, we strive to provide our patients with optimal care in a warm & comforting environment. We practice preventive dentistry, but also focus on caring for acute and chronic dental needs. We do our best to achieve early detection, early intervention, & prevention, and we hope to instill the same philosophy in our patients. Regularly scheduled office visits allow us to better assist you by identifying and managing potential dental issues more efficiently.

PREVENTION - DETECTION – INTERVENTION

Being proactive about your dental health can often help you prevent and/or prolong the onset of future problems. We firmly believe, and our experience has shown it to be true, that those patients who are consistent in keeping their appointments have fewer episodes, less difficulty with unstable chronic dental problems, and generally continue to enjoy better health overall.

As a general dental office, we provide a spectrum of services including everything from examinations and cleanings, to fillings, crowns, bridges, dentures, implant dentistry, Invisalign, whitening, emergency care, treatment of temporomandibular joint dysfunction (TMD), oral cancer screening, and much more. Dr. Hafsa and her staff are committed to doing everything possible to provide you with excellent dental care. Our practice is truly a family practice that is based on word-of-mouth referrals. To us, a referral is the best kind of compliment. We hope to build the kind of relationships with our patients that facilitate recommending us to friends and family.

The following information may also be very useful to you:

- At the time of your first appointment, we will listen closely to your concerns and conduct a thorough examination. This is one of the most critical aspects in creating a thorough treatment plan. The treatment plan will highlight the necessary steps to bring you to optimal dental health and also address your personal concerns.
- Before any treatment begins, we will sit down with you and advise you of your options so you can make an informed choice regarding the best treatment for your specific needs. We find it of utmost importance to keep you informed and knowledgeable throughout the process.
- For the benefit of our patients we are contracted with several insurance carriers as a provider. You will want to check your benefits booklet or with the benefits department of your employer to verify if we are listed as a provider within your network. As a part of our contract with the insurance companies we are legally required by the terms of the contract to collect any co-pays or deductibles from you at the time of service. We do ask that you be prepared to pay your co-pay at the time of check in.
- It is our desire to have a mutually respectful relationship with our patients. As part of the relationship we expect our patients to maintain a good credit rating with our office.
- Please make a complete list of all medications that you are currently taking and bring it with you to your first visit, as well as a detailed medical history which includes ALL medical issues you currently have or may have had in the past. For all subsequent visits, please provide us with any changes in medication or changes in your health.
- We have created a cancellation policy which we have all our patients review and sign at the initial visit. We utilize this policy to continue to operate efficiently and use the time that was reserved for you to help other patients in need.

If you have any questions or need further clarification of our practice philosophy or our policies, please do not hesitate to contact our office for assistance. Thank you. We look forward to working with you.

Sincerely,

Dr. Shadan Hafsa

☺ SMILE ANALYSIS ☺

When I see a picture of myself, the first thing I notice about my smile is: _____

Something I often notice about other smiles I consider attractive is _____

Aside from yourself, who is the next most important person you would want to "like" your new smile: _____

***Please mark an "X" by the statements below that you agree with.**

___ I wish the color of my teeth were whiter.

___ I wish I had a broader smile.

___I think some of my teeth are too large.

___I wish my teeth were straighter.

___I think my gums show too much when I smile.

___ I think my smile shows too much space between some of my teeth.

___Because I am not totally pleased with my smile, I sometimes hesitate to smile.

___ I have often wished I could change some the features of my smile.

___I feel as though I don't really know all the options available for enhancing my smile.

___Concerns over fees have prevented me from taking advantage of some the available option to enhance my smile.

___I feel as though I could do a better job protecting the health of my teeth and gums, and therefore the longevity of my own smile. ☺

Welcome

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Birthdate _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Phone (_____) _____ Work (_____) _____ Ext _____ Alt. Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Health History

Physician's Name_____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			
Do you wear contact lenses?	☐ Yes	☐ No						

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

Updates *(To be filled in at future appointments)*

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Dental Day, LLC

Thank you for choosing Dental Day. Our expert team of dentists, hygienists, and dental assistants look forward to serving all your dental needs. We have found that a clear understanding of what your dental needs are and the financial responsibility for your care are very important. Our policy is to provide each patient with a written estimate of recommended treatment. Our business staff will provide you with estimated cost of your treatment; however, we do encourage all patients to familiarize themselves with their insurance policies.

OFFICE AND FINANCIAL POLICIES

1. Dental Day requires that each patient per visit complete our patient verification form.

2. Dental Day expects that **all patient co-payments are due at the time services are rendered**. We do offer outside financing for extensive treatment. Financing is subject to approval by a participating financial group. For your convenience, we accept Cash, Personal Checks, MasterCard, Visa, American Express, and Debit Cards.

3. All patients having an existing account balance that are past due **will not** be rendered service until balance has been satisfied. All future treatment will be placed on hold until balance is paid in full. Any patient who has not paid their account in full will be subject to a $15 monthly late fee plus 1.5% monthly finance charge. **If it becomes necessary to refer your account to a collection agency, you will be responsible for collection fees of 33.3% the balance due plus reasonable attorney fees and costs.**

   _____(initials)

4. All collection lawsuits initiated by our attorneys will be in the state of Florida. Florida law shall control all such actions.

   _____(initials)

5. Dental Day charges a thirty-dollar ($30.00) fee for returned checks.

6. Dental Day reserves the right to obtain credit reports on patients when necessary.

   _____(initials)

7. Any patient who defaults on a payment arrangement by 10 days beyond the contractual date will be expected to pay the balance in full immediately.

8. Dental Day reserves the right to charge for broken and cancelled appointments. 24 hours cancellation notice is required for all appointments. Additionally, if we have not received a verbal confirmation by 2pm the business day prior to your scheduled appointment, your appointment will automatically be cancelled and you will need to reschedule. No show patients and same day cancellations will be charged a cancellation fee of $25.

9. Dental Day does not extend courtesy discounts to anyone.

10. All patients, under the age of eighteen, **must** be accompanied by parent or guardian who must remain on site while treatment is rendered to minor.

11. The parent or guardian of the minor will be responsible for all open balances of the minor.

    _____(initials)

12. Requests for Release of Documents and copies of x-rays will be completed within 15 days of request. $25 fee for copies need to be paid at time of request.

13. **Insurance balances are ultimately the patient's obligation. We file (most) insurances at no cost to you as a courtesy. We are glad to offer this service; however, insurance balances that are not paid after 60 days WILL be billed directly to you. Please keep your walk out statements and follow up with your insurance company to ensure that payment is in process. UNPAID BALANCES ARE YOUR RESPONSIBILITY AND NOT THAT OF YOUR INSURANCE CARRIER. YOU ARE ULTIMATELY RESPONSIBLE FOR THE YOUR ENTIRE BALANCE. ALL DISCREPANCIES IN PAYMENTS OR LACK OF PAYMENTS BETWEEN YOUR INSURANCE CARRIER AND YOU ARE YOUR RESPONSIBILITY.**

_____(initials)

14. **FURTHER YOUR INSURANCE PROVIDER MAY ONLY COVER A PORTION OF YOUR TOTAL BALANCE, RECIPET OF PARTIAL PAYMENT FROM YOUR CARRIER DOES NOT MEAN THAT YOUR BALANCE IS PAID IN FULL; YOU REMAIN RESPONSIBLE FOR THE DIFFERENCE BETWEEN EXPENSES PAID FOR BY YOUR INSURANCE AND THE ACTUAL BALANCE.**

_____(initials)

INSURANCE POLICIES

1. Dental benefits are based on a contract **between your company's insurance administrator and the individual participating in the plan. It is your responsibility to have yourself assigned to the correct dental site**.
2. **It is your responsibility to be familiar with restrictions, limitations and deductions that may apply to your plan.**
3. **All deductible or co-payment amounts must be satisfied at the time treatment is rendered. The** requested amount of co-payment is estimated on the information received from your insurance company. All claims that are rejected or adjusted by the insurance company will become your additional responsibility and payable to Dental Day immediately.
4. Patients who have insurance companies, of which Dental Day is not a participant, will be expected to pay the full amount of treatment at time of service. We will provide you with a statement of service to submit to your insurance carrier once balance is paid in full.

_____(initials)

5. Except for federal government, Dental Dental will only accept and submit to one insurance company.

COORDINATION OF BENEFITS

Dental Day will submit only to your primary insurance company, using the primary guarantor and birthday policies. We will gladly provide you with a statement of service to submit to your secondary insurance company.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

Dental Day, LLC

NOTICE OF PRIVACY PRACTICES (Dental)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

The Health Portability and Accountability Act of 1996 ("HIPPA) is a federal program that requires that all medical records and their individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA: provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Dental Day, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of these uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Dental Day, LLC

Authorization and Informed Consent for Dental Procedures

I hereby authorize and consent to an examination, including any necessary radiographs.

This is to acknowledge that if further dental treatment is required, I will receive a dental treatment plan prepared for me and explained to me, for treatment of my oral health, including costs of procedures and estimated insurance benefits. Further, I have been informed that other possible alternative methods of treatment, if any, have been discussed. If, during a procedure, any unforeseen condition shall arise in the course of the procedure, calling for the Doctor's judgment, or for procedures in addition to, or different from those now contemplated, I further request and authorize the Doctor to do whatever she may deem advisable.

Post-operative risks of the proposed treatment include, but are not limited to, swelling, pain, thermal sensitivity, gum recession, exposure of margins of crowns (caps), tooth mobility, food impaction between teeth, infection, phonetic interference and alterations of fit of present dental appliances.

Due to the unpredictability of individual healing responses and biologic principles beyond our control, no guarantee has been given to me that the proposed treatment will be curative and/or successful. It has been explained that the long-term success of treatment requires my cooperation and performance of plaque control, as well as periodic maintenance visits after the proposed treatment.

Appointments are scheduled with the utmost care and consideration. This time has been specifically reserved for you. Our staff will attempt to call to remind you about your appointment, but this is only a courtesy. We reserve the right to charge for appointments that are cancelled and/or broken without 24 hours advance notice.

I certify that I have read and fully understand the above consent for the procedures.

_____ _____

Signature of Patient of Legal Guardian Date