NIMA RAOUFINIA DDS LLC

SILVER SPRING
COSMETIC DENTISTRY

REGISTRATION FORM

(Please Print)

Today's date: _____/_____/________

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.

Social Security #: ________-________-_________	Birth date: _______/_______/__________	Age: _________	Sex: ❑ Male ❑ Female
Street address:	APT #:	City:	

State:	Zip Code:	Phone #: ( )	Home #: ( )
Occupation:	Work Phone #: ( )	Email:	

How did you find our office? ❑ Insurance Plan ❑ Family ❑ Friend ❑ Online

Website: ______________________________

Name of Person that Referred you: ________________________________

RESPONSBILE PARTY / INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: _____/_____/_____	Cell Phone #: ( )	Home Phone #: ( )
SSN: ________-________-_________			
Street address:	APT #:	State:	ZIP Code:

Relationship to patient: ________________________ Email: ____

Name of Insurance Company: _______________________________

Subscriber's name:	Subscriber's SSN: ________-________-_________	Birth date: _____/_____/________

Group #: __________________________ Policy # :_______________________

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child

Do you have a Secondary Insurance? ❑ Yes ❑ No

IN CASE OF EMERGENCY		
Name of local friend or relative: ________________________	Relationship to patient: ____________________	Phone #: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Nima Raoufinia DDS LLC. I understand that I am financially responsible for any balance that may not be paid by insurance company at the time services are rendered. I also authorize Nima Raoufinia DDS LLC or insurance company to release any information required to process my claims.		
Patient/Guardian signature		*Date*

DENTAL HISTORY AND INFORMATION

❑ Yes ❑ No - Do you like your smile?
❑ Yes ❑ No - Do you have any pain?
❑ Yes ❑ No - Do your gums bleed?
❑ Yes ❑ No - Do you Clench or Grind your teeth?
❑ Yes ❑ No - Do you require Antibiotics before your appointment?

Have you ever had a bad experience at a dental office? Please explain

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MEDICAL HISTORY AND INFORMATION

ALLERGIES:
❑ Yes ❑ No - LATEX
❑ Yes ❑ No - Codeine
❑ Yes ❑ No - Dental Anesthetics
❑ Yes ❑ No - Penicillin
Any other allergies NOT listed above: ____________________________________

CONDITIONS:
❑ Yes ❑ No - High Blood Pressure
❑ Yes ❑ No - Diabetes
❑ Yes ❑ No - Artificial Joint(s)
❑ Yes ❑ No - Artificial Heart Valves
❑ Yes ❑ No - Infective Endocarditis
❑ Yes ❑ No - Osteoporosis
❑ Yes ❑ No - HIV / AIDS
❑ Yes ❑ No - Heart Disease
❑ Yes ❑ No - Hepatitis A B C (Please Specify)
❑ Yes ❑ No - STD / Venereal Disease
❑ Yes ❑ No - ADHD
❑ Yes ❑ No - Seizures
❑ Yes ❑ No - Anemia
❑ Yes ❑ No - Angina
❑ Yes ❑ No - Arthritis
❑ Yes ❑ No - Blood Transfusion
❑ Yes ❑ No - Blood Disorder
❑ Yes ❑ No - Cancer
❑ Yes ❑ No - Emphysema
❑ Yes ❑ No - Fever Blister
❑ Yes ❑ No - Headaches / Migraines
❑ Yes ❑ No - Hormone Deficiency
❑ Yes ❑ No - High Cholesterol
❑ Yes ❑ No - Immunosuppresion
❑ Yes ❑ No - Kidney Disease
❑ Yes ❑ No - Gastrointestinal Problems
❑ Yes ❑ No - Liver Disease
❑ Yes ❑ No - Low Blood Pressure
❑ Yes ❑ No - Lung Disease
❑ Yes ❑ No - Tuberculosis
❑ Yes ❑ No - Psychiatric Problems
❑ Yes ❑ No - Rheumatic Fever
❑ Yes ❑ No - Glaucoma
❑ Yes ❑ No - Epilepsy / Fainting
❑ Yes ❑ No - Shingles / Chicken Pox
❑ Yes ❑ No - Asthma
❑ Yes ❑ No - Sinus Problems
❑ Yes ❑ No - Speech / Hearing Impairment
❑ Yes ❑ No - Drug / Alcohol Abuse
❑ Yes ❑ No - Stroke
❑ Yes ❑ No - Thyroid Problems
❑ Yes ❑ No - Heart Murmur

Any other conditions NOT listed above: ___________________________________

FOR WOMEN
-Are you Pregnant? ❑ Yes ❑ No
If YES, how many weeks? ___________________________________

-Are you taking birth control pills? ___________________________________

-Are you undergoing Hormone Therapy? ___________________________________

OFFICE POLICIES

FINANCIAL AGREEMENT
-An estimate of the cost of your recommended treatment plan will be provided at the end of your initial appointment.

-We accept cash, personal checks for amounts less than $200.00, all major credit cards and Care Credit as methods of payment.

INSURANCE
-If you have dental insurance, please note that we are only able to provide an estimate of benefits based on the information provided to our office by you and/or your dental plan. These estimates are not a guarantee that services will be covered. Limitations or exclusions that are not disclosed to our office by your dental carrier may exist in your plan.

-If you have multiple dental insurance plans, our office will bill a maximum of two dental insurances for you. Your estimated patient responsibility will be calculated based on your reported primary insurance benefits only. Once payment is received from your primary insurance, we will send a claim to your secondary insurance. Once payments from both your primary and secondary insurance are received, you will be notified of any patient credit or balance due.

-Dental insurance is a contract between the patient and the insurance carrier. Our office will accept assignment of benefits from insurance; however, ultimately, the entire bill remains your responsibility.
-In the event the dental plan does not cover your treatment, or if it is cancelled and/or terminated, or if it cannot be verified before your appointment, you are responsible for the full cost of all treatment performed. If and when payment is received from your insurance carrier, you will be notified of any credit or balance due.

-All patients are responsible for full payment of any balance due within (30) days of the date of service. Dental benefits are estimated as a courtesy to our patients. The final treatment cost will be determined by the dental plan.

-Failure to pay for treatment on time may result in collection procedures. If collection procedures are required, the patient is responsible for all collection costs

CONFIRMING APPOINTMENTS
As a courtesy, our office will send appointment reminders by phone calls or text messaging or e-mail.

KEEPING APPOINTMENTS
-Your appointment is a block of time that is especially reserved for your dental care. Please arrive 10 minutes before your scheduled appointment time so you have time for parking and to review appointment information.

-A late arrival jeopardizes the time available for your visit and our ability to be on time. Patients arriving 10 minutes late or more to an appointment may have to reschedule the appointment. Patients who arrive late to three appointments may be dismissed from the office.

-Patients who miss an appointment will incur a charge, **$50.00**. Patients who miss three appointments may be dismissed.

-For the consideration of your doctors and fellow patients, we require at least 24 hours' advance notice to change an appointment. Failure to provide the required 24-hour notice will incur a charge: **$50.00**

Notice of Privacy Practices
-I have been given the "Notice of Privacy Practice" and have read it carefully.

By signing below, I acknowledge that I understand agree to follow these policies.

Patient's Name:

____

Legal Guardian's name:

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Patient/Guardian signature: _________________________________ *Date:* ______________________

GENERAL DENTISTRY INFORMED CONSENT FORM

1. **EXAMINATION AND X-RAYS:** I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.

2. **CHANGES IN TREATMENT PLAN:** I understand that, during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination—the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions to the treatment plan as necessary.

3. **DRUGS, MEDICATION, AND SEDATION:** I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand this and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of any anesthetic medication or drugs that may be given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

4. **FILLINGS:** I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

5. **CROWNS, BRIDGES, VENEERS AND BONDING:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. I understand that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

6. **DENTURES – COMPLETE OR PARTIAL:** I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

7. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save a tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

8. **PERIODONTAL TREATMENT:** I understand that serious periodontal conditions causing gum inflammation and/or bone loss can lead to the loss of my teeth. I understand that treatment plans (non-surgical cleaning, gum surgery and/or extractions) may vary depending on the severity of periodontal conditions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

9. **REMOVAL OF TEETH (EXTRACTION):** I understand that if a tooth is not savable by e.g. root canal therapy, crowns, periodontal surgery, etc., it may be recommended that the tooth be extracted. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand that the following are some risks involved in having teeth removed: pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

10. **TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

CONSENT: *I have read and understood the above information. Further, I understand that dentistry is not an exact science; therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.*

Patient's Name:

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Legal Guardian's name:

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Patient/Guardian signature: ______________________________

Date: ____________________