# AESTHETIC COMPREHENSIVE DENTISTRY

We are a health- centered dental practice, thus we are concerned with your total well being, not just your oral health. An essential part of our approach is a thorough health history. Please fill out the health questionnaire below completely- even if some of the question may not seem relevant to your dental health. Thank you!

Full Name_____Date_____

Preferred Name_____Soc.Sec.No._____

Street Address_____

City_____ State_____ Zip Code _____Date of Birth _____ Age _____

Weight_____ Height _____ Single _____ Married _____ Widowed _____Divorced _____

Home Phone # _____ Work # _____ Cell # _____

Employer_____Occupation_____

E- Mail_____

What are your hobbies or special interests? _____

Who may we thank for referring you? _____

Person to contact in case of emergency_____ Phone # _____

**Health and Dental History**

Physician's Name_____ Phone #_____

Are you taking any medication now, including regular dosages of Aspirin? Yes No
If so, please list name and dosage_____

_____

Are you aware of having an allergic reaction to any medication or substance? Yes No
If so, please list_____

Have you been under the care of a medical doctor during the past two years? Yes No
If so, for what? _____

Have you seen an ENT (ear, nose and throat doctor)? Yes No Name_____

Have you seen a Chiropractor? Yes No Name_____

Have you seen a Neurologist? Yes No Name_____

Have you had braces? Yes No Name_____

Have you ever had any cosmetic procedure? Yes No If so, for what?_____

_____

NAME:_____

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

| | | | | | |
|---|---|---|---|---|---|
| Heart Concerns | Yes | No | Arthritis | Yes | No |
| Congenital Heart Disease | Yes | No | Tuberculosis | Yes | No |
| Heart Murmur | Yes | No | Lung Disease | Yes | No |
| Rheumatic Fever | Yes | No | History of Cancer | Yes | No |
| Low/High Blood Pressure | Yes | No | Thyroid Problems | Yes | No |
| Mitral Valve Prolapse | Yes | No | Stomach Problems/ Ulcer | Yes | No |
| Artificial Heart Valve | Yes | No | Migraines | Yes | No |
| Pacemaker | Yes | No | Headaches | Yes | No |
| Stroke | Yes | No | Jaw Pain | Yes | No |
| Asthma | Yes | No | Jaw Popping | Yes | No |
| Liver Disease | Yes | No | Limited Opening | Yes | No |
| Latex Sensitivity | Yes | No | Congested Ears | Yes | No |
| Artificial Joints | Yes | No | Dizziness | Yes | No |
| Kidney Problems | Yes | No | Ringing Ears | Yes | No |
| Radiation/ Chemotherapy | Yes | No | Loose Teeth | Yes | No |
| Epilepsy/ Seizures | Yes | No | Posture Problems | Yes | No |
| Diabetes | Yes | No | Clenching/ Grinding | Yes | No |
| Hepatitis | Yes | No | Facial Pain | Yes | No |
| AIDS/ HIV | Yes | No | Sensitive Teeth | Yes | No |
| Sickle Cell Disease | Yes | No | Neck Ache | Yes | No |
| Neurological Disorders | Yes | No | Bell's Palsy | Yes | No |
| Psychological Disorders | Yes | No | Difficulty Swallowing | Yes | No |
| Sinusitis | Yes | No | Difficulty Chewing | Yes | No |
| Muscle Relaxant | Yes | No | Trigeminal Neuralgia | Yes | No |
| Blood Thinner | Yes | No | Tingling in arms/fingers | Yes | No |
| Excessive Bleeding | Yes | No | Insomnia/ frequent waking | Yes | No |

| | | |
|---|---|---|
| **Has your partner noticed that you gasp or stop breathing during sleep?** | Yes | No |
| **Do you snore?** | Yes | No |
| **Do you sometimes feel excessively sleepy during the day?** | Yes | No |
| **Do you often wake up not feeling refreshed?** | Yes | No |
| Does your breath concern you? | Yes | No |
| Do you smoke or chew tobacco? | Yes | No |
| Do your gums bleed? | Yes | No |

**Please list medications**

_____

_____

**Women**: Are you: Pregnant?_____ Nursing?_____ Taking birth control pills?_____

Are you taking **Bisphosphonates?** _____

Do you have or have you had any surgery, disease, condition or problem not listed? Yes No

If so, please list _____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature_____Date_____

| _____ | _____ | _____ | _____ | _____ | _____ |
|---|---|---|---|---|---|
| Initial | Date | Initial | Date | Initial | Date |

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine you present and future dental needs. Here are the topics we are going to be talking about at your first visit. . Please check what best expresses how you feel about the following questions:

- Are you having any areas of concern? _____
- Tell us, in your opinion, What you think the present state of the health of your mouth is?_____
  _____
- What do you already know about our office and what are your expectations?_____
  _____
- How healthy do you want us to get your mouth?

  Don't really care  Average  the best it can be
- Should you need treatment, at what point should we address it?
  ___ When my tooth hurts or breaks
  ___ When something is worsening
  ___ When something isn't ideal
- What quality of dentistry do you want us to recommend?

  Just patch it  Average  Ideal/ the best
- We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? ( please circle)

  As a **general** dentist  As a **cosmetic** dentist  As a **functional** dentist
- How do you feel about the **appearance of your smile**? _____
  _____
- What would it take for you to trust us to be your dentist? _____
  _____
- Tell us about your **good** dental experience…_____
  And the **bad** ones…_____
- Has fear ever been an issue for you in a dental office? _____
- What caused you to leave your last dental office? _____
- Has time ever been a factor in getting your dental work done? _____
- Has the cost of dental treatment been a concern for you? _____
  What can we do to help you with this? _____

Is there any additional information you would like us to know? _____
_____

**Sherry Kazerooni, D.D.S.**
**Today's Dental, Inc.**
**8347 Greensboro Drive – Suite B**
**McLean, VA 22102**
**(703) 827-0644**

---

## FINANCIAL POLICY

**Missed Appointments**

Our policy is to charge for missed appointments at the rate of **$75.00 per hour**. Please help us serve you and our other patients better by keeping your scheduled appointments. If you do need to change or reschedule an appointment, we ask that you provide us with at least **48 BUSINESS HOURS** advance notice so that we may offer that appointment to a patient that may be waiting.

**Payment**

We are committed to the complete success of your treatment. Please understand that the payment of your bill is considered part of your commitment to your treatment.

**AS A COURTESY**, if you have notified us that you have a dental insurance plan/benefit, we will submit your claim to the appropriate insurance company for reimbursement. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits and your insurance company has NOT paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your dental insurance policy.

Our practice is committed to providing you the BEST treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customer rates.

All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account

I have read the Financial Policy. I understand and accept the terms of the above outlined policy

| _____ | _____ | _____ |
|---|---|---|
| *Patient Name | *Patient Signature | *Date |

**Sherry Kazerooni, D.D.S.**
**Today's Dental, Inc.**
**8347 Greensboro Drive – Suite B**
**McLean, VA 22102**
**(703) 827-0644**

---

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

**PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF EACH VISIT**

We now offer the following payment options for your convenience:

_____ *Payment by cash

_____ *Payment by check

_____ *Payment by credit card

_____ *Payment by Care Credit Patient Financing

Please make your choice(s), sign below and return to the office for processing.

Our office is a fully approved and accredited provider of the VISA/MasterCard HealthCare Program – which enables you to use VISA, MasterCard, American Express and Discover credit cards.

Additionally, our office offers extended payment arrangements through our third-party billing company, Care Credit. They offer flexible repayment terms – up to 60 months – to help make your treatment work within your budget. Credit approval is required.

| _____ | _____ | _____ |
|---|---|---|
| *Printed Name | *Signature | *Date |

## Sherry Kazerooni, D.D.S.
## Today's Dental, Inc.

# HIPAA 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 and will 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 (insurance company).
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the 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 below for a current copy of the *Notice of Private Practices*.

Additionally, I may authorize another party to be privy to my personal health information and to discuss treatment or account information. If I have elected another party, I have indicated their name and relationship to me below.

_____ _____
Name Relationship

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 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 Practice Acknowledgment, but was unable to do so as documented below.

_____
Date: Initials: Reason: