Welcome

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ (Last Name / First Name / Middle Initial) Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Business Email _____

Primary Insurance

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Insurance Address _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Pharmacy _____ Phone _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Business Phone _____

Subscriber Employed by _____ Business Email _____

Insurance Company _____ Phone _____ Insurance Address _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides.

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

❑ Y ❑ N Bad breath ❑ Y ❑ N Food collection between teeth ❑ Y ❑ N Periodontal treatment ❑ Y ❑ N Sensitivity to sweets

❑ Y ❑ N Bleeding gums ❑ Y ❑ N Grinding or clenching teeth ❑ Y ❑ N Sensitivity to cold ❑ Y ❑ N Sensitivity when biting

❑ Y ❑ N Clicking or popping jaw ❑ Y ❑ N Loose teeth or broken fillings ❑ Y ❑ N Sensitivity to hot ❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ How often do you floss? _____ How do you feel about the appearance of your teeth? _____

Do you wish your teeth were straighter? ❑ Y ❑ N Do you wish your teeth were whiter? ❑ Y ❑ N

Are you unhappy with the fillings, crowns or bridges? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Medical History

Physician's name _____ Address _____ Phone _____

Physician's Email _____ Date of last visit _____

Have you had any serious illnesses or operations? ❑ Y ❑ N If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Do you smoke or use other tobacco/smokeless products? ❑ Y ❑ N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other _____

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check Y for yes or N for no if you have or have not had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic fever
❑ Y ❑ N Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

List medications you are currently taking, if any:

_____

List drug allergies, if any:

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Assignment of Benefits Form

Practice Name: General and Cosmetic Dentistry of Downey, office of Dr Abadi
Address: 10735 Lakewood Blvd. Downey Ca. 90241
Patient_____ Date _____
City, State, Zip _____ ID#_____
Phone_____ Group #_____

I, _____, understand that services rendered to me by Dr. Abadi and associates are my financial responsibility and that the provider will bill my insurance company _____, as a courtesy, I authorize my insurance company to pay my benefits directly to Dr Behzad Abadi DMD Inc. and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above - mentioned assignee and I have agreed to pay, In a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines, I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____Insurance company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there might be associated costs for providing information beyond what is necessary adjudication of a clean claim.

I also unerstand that should my insurance company send payment to me, I will forward the payment to Dr. Behzad Abadi within 48 hours. I agree that if I fail to send this payment to Dr Abadi and they are forced to proceed with collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's selection, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Dr. Abadi to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this assignment shall be consider as effective and valid as the original.

I authorize Dr Abadi to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ Witness_____

_____ _____
Signature of policyholder Patient or Guardian

First Name_____ Last Name_____

Dental HIPAA Notice

HIPAA Notice of Privacy Practices for Personal Health information

Dear patient:

This is your Health information privacy notice from our dental practice. Please read it carefully. The doctors and staff at Dr Behzad Abadi's Dental office strongly believe in protecting the confidentiality and security of information we collect about you.

This notice describes how we protect the personal health information we have about you.

We are required by law to:

- **maintain the privacy of your Personal Health Information ;**
- **provide you this notice of our legal duties and privacy practices with respect to your personal Health information; and**
- **follow the terms of this notice.**

We protect your Personal Health Information from inappropriate use or disclosure. Our employees, and those of companies that help us service your dental care, are required to comply with our requirements that protect the confidentiality of Personal Health Information, They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services.

By signing this form, you acknowledge our efforts to maintain the privacy and confidentiality of your personal health information.

_____ _____

Patient's Signature **Date**

GENERAL AND COSMETIC DENTISTRY OF DOWNEY
10735 LAKEWOOD BLVD. | DOWNEY, CA 90241 | (562)862-8128

Written Financial Policy

Thank you for choosing Dr. Behzad Abadi, DMD, Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Visa, MasterCard®, American Express®, Discover Card® or CareCredit® Healthcare Credit Card
- Convenient Monthly Payment Options 1) from CareCredit and 2) Lending Club.
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Dr. Behzad Abadi, DMD. requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring more than 2 appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $500 or more, a 50% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $100 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.

Dr Behzad Abadi, DMD, charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.