WELCOME TO B. ABADI DMD INC.

Thank you for selecting our healthcare team! To help us meet all your dental healthcare needs, please fill out the front and back sides of this form. If you have any questions or need assistance, please ask us

We will be happy to help!

Patient Information (Confidential)

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Marital Status Please Circle: Minor Single Married Divorced Other

Circle Appropriate Box: **MALE** **FEMALE**

Birthdate: _____ Social Security Number: _____

Driver's License State/Number: _____ Email:_____

Home #: _____ Cell #: _____

Employer: _____ Work #: _____

Employer Address: _____

Current Physician's Name: _____ Phone: _____

Person to Contact in Case of Emergency: _____ Phone: _____

Whom may we thank for referring you? _____

Responsible Party

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State_____ Zip Code: _____

Marital Status Please Circle: Minor Single Married Divorced Other

Circle Appropriate Box: **MALE** **FEMALE**

Birthdate: _____ Social Security Number: _____

Driver's License State/Number: _____

Home #: _____ Cell #: _____

Employer: _____ Work #: _____

Insurance Information

Subscriber Name: _____ Relationship to Patient: _____

Social Security Number: _____ DOB: _____

Insurance Carrier: _____ Group #: _____

Ins. Co. Address: _____ Phone: _____

Patient Medical History **Circle One**

1. Are you under medical treatment now? YES NO
2. Have you ever been hospitalized for any Surgical operation or serious illness within the last 5 years? YES NO
   If yes, please explain _____
3. Are you taking any medication(s) including non-prescription medicine? YES NO
   If yes, what medications are you taking? _____
4. Have you ever taken Phen-Fen/Redux? YES NO
5. Do you use tobacco? YES NO
6. Do you use controlled substances? YES NO
7. Are you wearing contact lenses? YES NO
8. Do you take or have you ever taken Bisphosphonates (Fosamax,Boniva,Actonel,Aredia,Zometa, etc.) for Osteoporosis or any other conditions? YES NO
9. Do you take antibiotics prior to dental treatment? YES NO
10. Do you have Body Implants/Artificial Joints: YES NO

11. Do you have or have you had any of the following?

High Blood Pressure	YES	NO	Heart Disease	YES	NO
Heart Attack	YES	NO	Cardiac Pacemaker	YES	NO
Rheumatic Fever	YES	NO	Heart Murmur	YES	NO
Swollen Ankles	YES	NO	Angina	YES	NO
Fainting/Seizures	YES	NO	Frequently Tired	YES	NO
Asthma	YES	NO	Anemia	YES	NO
Low Blood Pressure	YES	NO	Emphysema	YES	NO
Epilepsy/Convulsions	YES	NO	Cancer/Chemotherapy	YES	NO
Stomach Problem/Ulcers	YES	NO	Arthritis	YES	NO
Sexually Transmitted Disease	YES	NO	Joint Replacement	YES	NO
Kidney Disease	YES	NO	Hepatitis/Jaundice	YES	NO
AIDS or HIV Infection	YES	NO	Diabetes	YES	NO
Thyroid Problem	YES	NO	Leukemia	YES	NO
Chest Pains	YES	NO	Easily Winded	YES	NO
Stroke	YES	NO	Hay Fever	YES	NO
Tuberculosis	YES	NO	Glaucoma	YES	NO
Recent Weight Loss	YES	NO	Liver Disease	YES	NO
Respiratory Problems	YES	NO	Heart Trouble	YES	NO
Mitral Valve Prolapse	YES	NO	Radiation/Therapy	YES	NO
Congenital Heart Lesions	YES	NO	Stent	YES	NO
Jaundice	YES	NO	Other_____	YES	NO

12. Are you allergic or have you had any reactions to the following?
    - Local Anesthetics (e.g. Novacaine)..... YES NO
    - Penicillin or any other Antibiotics ..... YES NO
    - Sulfa Drugs ..... YES NO
    - Aspirin/Codeine..... YES NO
    - Any Metals (Nickel, Mercury, etc)..... YES NO
    - Latex Rubber..... YES NO
    - Other (please list)..... YES NO
13. Women Only:
    - Are you pregnant or think you may be pregnant? YES NO
    - Are you nursing? YES NO
    - Are you practicing birth control? YES NO

Authorization and Release

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I assign directly to B. ABADI D.M.D., INC. 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 dentists named above may use my health care information. They may disclose such information to the Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Patient's Signature Date

_____ _____

Doctor's Signature Date

First Name: _____ **Last Name:** _____

DENTAL HIPPA 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 B. ABADI D.M.D., INC, 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

B. ABADI D.M.D., INC.

16633 VENTURA BLVD STE 850 | ENCINO CA, 91436 | (818) 990-5900

Written Financial Policy

Thank you for choosing B. ABADI D.M.D., INC.. 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

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with Cash prior to completion of care for treatment plans of $500 or more.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

B. ABADI D.M.D., INC. 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 20% 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.

B. ABADI D.M.D., INC , 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.

Assignment of Benefits Form

Practice Name: **B. ABADI DMD INC, office of Dr. Abadi**
Address: **16633 Ventura Blvd Ste. 850, Encino, CA 91436**

Patient First and Last Name:_____ DOB:_____
Address: _____City, State, Zip_____
Patients phone#_____ ID#_____ 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 and 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 understand 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 the 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 the provider. Any violations of this agreement will, at the provider's selection, terminate patient charge privileges with the provider and bring any balance owed by the patient to the 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 considered as effective and valid as the original.

I authorize Dr. Abadi to initiate a complaint or file an 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