Graceful Dentistry

Welcome!

Thank you for selecting Graceful Dentistry as your dental healthcare team! We will strive to maintain your information with utmost confidentially. To help us meet all of your dental healthcare needs, please fill out this form completely. If you have any questions, please ask.

Today's Date: _____ Patient Name (Last, First, Preferred): _____

DOB: _____ SSN (not required for minors): _____ Gender: ☐ M ☐ F

Street Address: _____ May we contact you via: ☐ Text ☐ Email

City, State, Zip: _____ Cell ph#_____

Email: _____ Home ph#:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Minor ☐ Widowed ☐ Separated

Work ph#:_____ ext: _____

Employer / School (if student) Name: _____

Please circle your primary dental focus:

Comfort Cost Cosmetics Longevity

Whom may we thank for referring you?: _____

Emergency Contact Name: _____ Ph#:_____

Financial Responsible Party (to whom should statements & billing concerns be addressed?) if different than patient:

Name: _____ Relationship to Patient: _____

DOB: _____ SSN: _____ Gender: ☐ M ☐ F

Already a patient in our office? : ☐Yes ☐NO

May we contact them via: ☐ Text ☐ Email

Street Address: _____ Cell ph#_____

City, State, Zip: _____ Home ph#:_____

Email: _____ Work ph#:_____ ext:_____

DENTAL Insurance Policy Information (PRIMARY)

Policyholder Name: _____ Relationship to Patient: _____

DOB: _____ SSN (required)*: _____ Member ID# _____

Employer Name: _____ Group#_____

Name of Insurance Company: _____ Provider Ph#_____

Claims Mailing Address: _____

Have you used any benefits yet of your current benefit year? ☐Yes ☐NO

DENTAL Insurance Policy Information (SECONDARY)

Policyholder Name: _____ Relationship to Patient: _____

DOB: _____ SSN (required)*: _____ Member ID# _____

Employer Name: _____ Group#_____

Name of Insurance Company: _____ Provider Ph#_____

Claims Mailing Address: _____

Have you used any benefits yet of your current benefit year? ☐Yes ☐NO

I authorize Hamid K. Namazi DDS, LLC (Graceful Dentistry) to release **any** information necessary to the insurance companies listed above, on my behalf in order to process my claims accurately. I authorize my insurance company(ies) listed above to pay directly to Hamid K. Namazi DDS, LLC (Graceful Dentistry) any benefits otherwise payable to me.

The above information is true to the best of my knowledge:

_____ _____

Patient / Guardian Signature Date

(PLEASE REVERSE PAGE--->)

MEDICAL HISTORY

Are you currently being treated for an active disease or condition?	☐Yes ☐NO	If yes, please list:_____ PCP Name: _____
Have you ever been hospitalized or had a major operation?	☐Yes ☐NO	If yes, please list with dates: _____ _____
Have you ever had a serious head or neck injury?	☐Yes ☐NO	If yes, please describe, list dates:_____ _____
Are you currently taking and medications, pills or drugs?	☐Yes ☐NO	If yes, please list:_____ _____
Do you take or have you <u>ever</u> taken: Phen-Fen or Redux?	☐Yes ☐NO	If yes, please list dates:_____ _____
Have you ever taken: Fosamax, Boniva, Actonel, or any other drug containing *bisphosphonates?*	☐Yes ☐NO	If yes, please specify:_____ _____
Are you on a special diet?	☐Yes ☐NO	If yes, please explain:_____ _____
Do you use tobacco?	☐Yes ☐NO	
Do you use controlled substances?	☐Yes ☐NO	If yes, please list:_____

WOMEN ONLY, are you:

☐ Pregnant (weeks_____) ☐ Nursing ☐Taking oral contraceptives

Allergies:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal _____ ☐ Latex ☐ Sulfa Drugs

☐ Local Anesthetics ☐ Other (non-seasonal / non-food)

:_____

Do you have, or have you <u>ever</u> had, any of the following?

☐ AIDS / HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Recent Weight Loss
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A / B / C Please circle	☐ Renal Dialysis
☐ Anaphylaxis	☐ Drug Addition Recovering? ☐Yes ☐NO	☐ Herpes	☐ Rheumatic Fever
☐ Anemia	☐ Easily Winded	☐ High Blood Pressure	☐ Rheumatism
☐ Angina	☐ Emphysema	☐ High Cholesterol	☐ Scarlet Fever
☐ Arthritis / Gout	☐ Epilepsy / Seizures	☐ Hives / Rash	☐ Shingles
☐ Artificial Heart Valve Date:_____	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Artificial Joint Date:_____	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Asthma	☐ Fainting spells / Dizziness	☐ Kidney Problems	☐ Spina Bifida
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Stomach / Intestinal Disease
☐ Blood Transfusion Date:_____	☐ Frequent Diarrhea	☐ Liver Disease	☐ Stroke
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Bruise Easily	☐ Genital Herpes	☐ Lung Disease	☐ Thyroid Disease
☐ Cancer	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chemotherapy	☐ Hay Fever	☐ Osteoporosis	☐ Tuberculosis
☐ Chest Pains	☐ Heart Attack / Failure	☐ Pain in Jaw Joints	☐ Tumors / Growths
☐ Cold Sores / Fever Blisters	☐ Heart Murmur	☐ Parathyroid Disease	☐ Ulcers
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Psychiatric Care	☐ Venereal Disease
☐ Convulsions	☐ Heart Trouble / Disease	☐ Radiation Treatments	☐ Yellow Jaundice

Other conditions not listed above: _____

The above information is true to the best of my knowledge:

_____ _____

Patient / Guardian Signature Date

Financial Policy

Hamid Namazi, DDS
3525 W. Dublin-Granville Rd.
Columbus, OH 43235

We at *Graceful Dentistry* are pleased you chose us to facilitate and care for your dental health needs. In order for us to keep costs as low as possible, we require that payment is made at time of service. The following is a statement of our financial policy, which we require you read and agree to prior to treatment.

Payment Options

- We accept Cash, Checks, master Card, Visa and Bank Debit cards.
- We offer extended Payment plans with no interest through third party financing with Cared Credit to those who qualify. Care Credit offers flexibility, and low payments for those who prefer low monthly payments
- Other financial arrangements are reserved for major work to be performed over $2,000. We will be happy to discuss these options with you if the situation applies.

Insurance

For those patients who have financial assistance from insurance, your estimated co-insuranc amount is due this time. We will continue to submit your claim for you; however, your insurance is a contract between you your employer, and the insurance company. As your dental provider our relationship is with you, not the insurance company.
All charges incurred are the responsibility of the patient regardless of your insurance coverage. We will cooperate fully with the regulations and requests of your insurance company that my assist in your claim being paid. Disputes or denied claims should be directed to your insurance carrier and/or employer.
Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received within 60 days from the date of filing, or your claim is denied, you will be responsible for paying the full amount at that time. If we receive any payment from your insurance company and you have paid your bill in full, we will remit the payment directly to you.

Emergency Patients

We require full payment for those seen for emergency appointment. We will file any insurance claims and reimbursement directed to you for this initial visit. Once established as a patient of record we will then only require you co-insurance at time of service.

Minors of Separated or Divorced Parents:

When two parents are each responsible for portions of a child's dental care, ***the Parent or Guardian who brings the child is responsible*** for co-insurance and full fee at date of service. They are also responsible for collecting payment from the other parent. Prearrangements must be made with our office if another party will be bringing the child for his appointment.

Returned Checks/ NSF

A $ 25.00 fee will be assessed for all returned or NSF checks. We reserve the right to reject check payments one a NSF occurs.

Short Notice Cancellations and Broken Appointments.

Each appointment is reserved time for you and only you. Each time appointments are not kept; other patients who do value their reserved time for treatment are penalized.
A $35.00 or more charge may be assessed for cancellations without a 48 hour notice or a missed appointment. We reserve the right to decline future appointments unless paid in full. We may also require your next visit be secured with a credit card deposit. This office and situation will determine when this should occur.

PLEASE TURN OVER FOR SIGNATURE PAGE

Financial Policy

Hamid Namazi, DDS
3525 W. Dublin-Granville Rd.
Columbus, OH 43235

I have read and understand the financial policies of Dr. Namazi and Graceful Dentistry. I understand I am responsible for all fees incurred for my dental treatment.

_____Patient initials

I understand insurance plans are payment assistance programs; they are not designed to cover the entire cost of treatment. I understand my insurance carrier may pay less than the actual bill for services. By signing this form I have authorize assignment of benefits directly to Dr. Namazi and this practice.

_____ Patient initials

I understand I am responsible for any and all charges that might occur if my account is turned over for collections.

_____ Patient initials

*Signed*_____ *Date:* ____/____/_____
Patient Signature

Parent
Or/ Guardian of: _____
Name of Minor

HIPAA OMNIBUS RULE:

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we ***may not*** *be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____	_____	_____
Please ***print*** your name	Please ***sign*** your name	Date

_____	_____
Phone Number	Email

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone

☐ Home Phone Confirmation ☐ Email Confirmation

☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**

☐ Text Message ☐ **None of the above** (opt out)

☐ Email

Photo Consent Form:

PLEASE CONTINUE TO PAGE 2

I hereby give Graceful Dentistry and any and all employees and/or agents of Graceful Dentistry the right and permission to use and/or publish photographs of me for art, promotional and educational purposes (including but not limited to, advertising, publicity, commercial or display of use).

Release of Claims:

I hereby release and discharge Graceful Dentistry and all persons functioning under his/her permissions or authority from any legal or equitable claims including but not limited to the following: blurring of the image(s), alteration, distortion or use in composite form, libel, invasion of privacy or any claims based on the production or in the process of recording or publishing the materials.

Initial the following:

_____ Yes, you may use my photos

_____ No, please do not use my photos

Signature: _____
Date:_____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____ I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign because (please describe)
_____

Signature of Privacy Officer _____