Patient Information:

Name______________________________ Age________Sex________ Home Phone (   )__________________
First MI Last
Address______________________________ Apt. No.______________ Work Phone (   )__________________
City__________________________ State______ Zip__________________ Other Phone (   )__________________
Birthdate______________ SSN______________________________ __________________
Month Day Year
DRIVERS LICENSE NUMBER STATE
Employer / Occupation______________________________ Address______________________________
In case of emergency, contact:______________________________ Relationship______________________Phone (   )__________________
Are any of your family members patientsof this practice? Yes No Name______________________Relationship__________________

IF THE PERSON RESPONSIBLE FOR THE ACCOUNT IS DIFFERENT THAN THE PATIENT, PLEASE FILL IN THIS SECTION:

Name______________________________ Age________Sex________ Home Phone (   )__________________
First MI Last
Address______________________________ Apt. No.______________ Work Phone (   )__________________
City__________________________ State______ Zip__________________ Employer __________________
Birthdate______________ SSN______________________________ __________________ Address__________________

Primary Dental Insurance: (Leave blank only if no dental benefits)

Name______________________________
Address______________________________
City__________________ State______ Zip____________
Phone__________________ Group No.__________________
Policy Number______________________________

Name of insured if different than patient:

Name______________________________
Address______________________________
City__________________ State______ Zip____________
Birthdate______________ SSN______________________________
Employer______________________________

Secondary Dental Insurance: (Leave blank only if no dental benefits)

Name______________________________
Address______________________________
City__________________ State______ Zip____________
Phone__________________ Group No.__________________
Policy Number______________________________

Name of insured if different than patient:

Name______________________________
Address______________________________
City__________________ State______ Zip____________
Birthdate______________ SSN______________________________
Employer______________________________

Dental History

What is the reason for the appointment? ______________________________
Are there any specific dental problems we should be aware of?______________________________
Do you think you have any decay or cavities? ❒Yes ❒No How often do you brush?______________________
Do your gums bleed easily when brushing or flossing? ❒Yes ❒No How often do you floss?______________________
Do you suffer from chronic bad breath or bad taste? ❒Yes ❒No
Do you have any jaw joint cracking or pain? ❒Yes ❒No
What was the purpose of your last dental appointment? ______________________ When was that?______________________
When was the last time you had a dental cleaning? ______________________ Name of previous dentist?______________________
When were the last full mouth x-ray taken of your teeth?______________________
How would you describe your dental health? ❒Excellent ❒Good ❒Fair ❒Poor
Whom may we thank for referring you to our office?______________________

Patient Treatment Consent.

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutuaIly agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This Form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist($) to release treatment records / x-rays or any other information deemed pertinent to my insurance carrier as necessary and /or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment will be assessed a service charge of 1.5% per month.

Patient I Parent or Guardian Signature: ______________________________________ Date:__________________

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all questions in detail.

Do you have or have you ever been treated for:

Condition	Yes	No
Any Heart Problems	❒Yes	❒No
Heart Murmur	❒Yes	❒No
Mitral Valve Prolapse	❒Yes	❒No
Heart Valve Defect	❒Yes	❒No
Heart Valve Replacement	❒Yes	❒No
Rheumatic Fever	❒Yes	❒No
Artificial Joint (Hip / Knee)	❒Yes	❒No
Angina	❒Yes	❒No
Stroke	❒Yes	❒No
Heart Attack	❒Yes	❒No
Bypass	❒Yes	❒No
Pacemaker	❒Yes	❒No
High Blood Pressure	❒Yes	❒No
Low Blood Pressure	❒Yes	❒No
Any Bleeding Disorders	❒Yes	❒No
Anemia	❒Yes	❒No
Hemophilia	❒Yes	❒No
Sickle Cell Trait	❒Yes	❒No
Blood Transfusions	❒Yes	❒No

Condition	Yes	No
Do You Smoke	❒Yes	❒No
Lung / Breathing Problems	❒Yes	❒No
Asthma	❒Yes	❒No
Bronchitis	❒Yes	❒No
Emphysema	❒Yes	❒No
Tuberculosis	❒Yes	❒No
Sinus Trouble	❒Yes	❒No
Difficulty In Healing	❒Yes	❒No
Diabetes	❒Yes	❒No
Thyroid Problems	❒Yes	❒No
Adrenaupituitary Problems	❒Yes	❒No
Liver Problems I Dysfunction	❒Yes	❒No
Hepatitis I Jaundice	❒Yes	❒No
Kidney Problems /Dysfunction	❒Yes	❒No
Stomach Trouble /Ulcers	❒Yes	❒No
Nervous Or Mental Disorder	❒Yes	❒No
Epilepsy Or Seizures	❒Yes	❒No
Alcoholism	❒Yes	❒No
Drug Abuse	❒Yes	❒No

Allergic Reaction (Hives/Swelling) To:

Condition	Yes	No
Penicillin	❒Yes	❒No
Erythromycin	❒Yes	❒No
Sulfa	❒Yes	❒No
Codeine	❒Yes	❒No
Aspirin	❒Yes	❒No
Latex	❒Yes	❒No
Local Anesthetic (Novocain)	❒Yes	❒No
Other Medications Or Substances? Please List:	❒Yes	❒No

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Condition	Yes	No
Cancer/Tumorother Growths	❒Yes	❒No
Chemotherapy /Radiation	❒Yes	❒No
Sexually Transmitted Disease	❒Yes	❒No
Other Infectious Diseases	❒Yes	❒No
Hiv/Aids	❒Yes	❒No
Are You Pregnant?	❒Yes	❒No

Do you need to take antibioticpremedication prior to dental appointments? ❒Yes ❒No ❒Don't Know Name of Antibiotic: ______________________

Do you have any current health problems not noted above? ❒Yes ❒No What?______________________

Are you: currsntly being treated by a physician? ❒Yes ❒No Why?______________________

Physician's name, address and phone:______________________

Are you presently taking any medications, pills, or tonics? ❒Yes ❒No List: ____________ For: ____________
(I.E.; Blood Pressure, Birth Control, Steroids, Hormones) ____________ For: ____________
____________ For: ____________

Is there any condition or problem relating to your medical history that has not been mentioned? ❒Yes ❒No Explain:______________________
____

Initial and Yearly Review of Patient Medical History

No Change	Change	List:	Date	Parent/Guardian Signature	Doctor/Hygienist Signature
❒	❒				
❒	❒				
❒	❒				
❒	❒				
❒	❒				
❒	❒				
❒	❒				

Medical Alert Recommended? Yes No Date Interviewer Notes

1)______________________ ______________________

2)______________________ ______________________

3)______________________ ______________________

4Premedication Recommended? Yes No ______________________

Rx:______________________ ______________________

Aesthetic Dental Center of Columbia
10700 Charter Drive, Ste. 340, Columbia MD, 21044

In order for our office to provide a safe and sterile environment for all our patients during treatment there will be an Osha (sterilization) Fee per visit of $10.00. The fee will be charged as applicable.

Signature: ______________________________ Date: ______________

Aesthetic Dental Center of Columbia

10700 Charter Drive – Suite 340 – Columbia, MD 21044
(410) 730-7779

We welcome you to the dental practice of Dr. Mahvash Zulfaghary and Associates. We are committed to providing you with the best possible dental care at the lowest cost. Since our practice also has financial obligations which must be met, we ask that all patients pay for their examinations and treatment in full on the day of each visit to our office.

In the event that your insurance coverage changes to a plan where we are not participating providers, you will be responsible for payment of all fees at the time service is rendered. Please be aware that few insurance companies attempt to cover all dental costs. Some pay fixed allowances for each procedure while others pay only a percentage of the costs. Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary to the area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates which may bear no relationship to the current standard and cost of care in this area. We need your assistance and your understanding of our payment policy as follows:

8. All patients are responsible to make sure their bills are paid in a timely fashion. For your convenience, we accept VISA, MasterCard, Personal Checks, and Cash. Please do not bring large denominations of currency for small payments. There will be a $35 fee for any checks returned.

9. As a courtesy to you, we will bill your insurance company if you provide us with the correct policy or claim numbers, name of insured, and exact address at the time of your visit. **We will no longer accept multiple insurance plans unless prior arrangements have been made with our billing department.** We require a $100 deposit if you do not have all of the information prior to being seen by our doctors.

10. We will allow 45 days for your insurance company to make payment. Your insurance company may require additional information from you before they process your claim. Please respond promptly to their request. **You will be expected to pay your account balance if your insurance has not paid after 45 days.**

11. HMO/PPO patients are asked to review their particular guidelines. Coverage may vary widely among individual groups. We may not be aware of rules unique to your group. We make every effort to provide the care you need within your plan rules. Please do not ask to be treated without the proper insurance information. **All HMO patients are required to pay their co-payments at the time of service.** While each patient's dental problems differ and it is often impossible to estimate the total cost of services before they are rendered, it is advisable that you obtain estimates on all treatment plans whenever possible so that you are aware in advance as to what your co-pay will be.

12. Original dental records and X-Rays are part of your permanent dental record and must remain in our office. Copies of dental records and X-Rays may be obtained **with no less than 21 days advance written notice**. Costs are established in accordance with the Maryland State Board of Medical Examiners. The current rate is $15.00 for retrieval and preparation of records, $ .50 per page for copying, $1.00 for each bite wing or periapical film, $4.00 for a panoramic film and the actual cost of postage should it apply. **The fee for this service must be paid for prior to receiving your copies.**

13. **Aesthetic Dental Center of Columbia requires payment at the time service is rendered.** All balances over 30 days will be charged 1.5% per month. If it is necessary to turn your account over to collection, your fees for service will be adjusted to reflect our full UCR and there will be an additional charge of 1/3 of your total balance to cover attorney fees. All court costs and any other cost associated with collection of this account will be your responsibility.

14. **Cancellation of appointments is required 48 hours in advance.** It is the policy of this office to charge $25.00 per half hour of any appointment missed or cancelled less than 48 hours in advance.

Our practice firmly believes that a good Dr./Patient relationship is based upon understanding and good communication. Thank you for understanding our Financial Policy. If you have any questions regarding financial arrangements, please feel free to speak to our Office Manager. We will make every effort available to you to clarify any misunderstanding you may have concerning your balance. We are here to help you.

I have read and received a copy of the above Financial Policy and accept financial responsibility for services rendered.

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Patient/Guardian Signature **Date**