PERSONAL INFORMATION

Name_____ Birthday_____ Age_____ Soc. Sec. #_____ Marital Status_____

Home Address_____ City_____ Zip_____ Home ☎ _____

Cell ☎_____ E-mail💻_____ Occupation_____

Employer_____ Business ☎ _____ Dental Insurance_____

Spouse Name_____ Spouse's Employer_____ Spouse's Insurance_____

Referred By _____ Nearest Relative for Emergency Contact and ☎_____

MEDICAL HISTORY

Physician Name_____ Physician ☎ _____ When was your last physical exam?_____

Are you in good health? Yes☐ No☐ If no explain_____ Existing Illness? Yes☐ No☐ If yes explain_____

Do you bleed excessively? Yes☐ No☐ Do you smoke? Yes☐ No☐ Have you been told you need antibiotics before dental treatment? Yes☐ No☐

Are you taking any medications, pills or drugs? Yes☐ No☐ If yes, please list_____

Have you ever taking any of the following medications: Fen-Phen or Redux Yes☐ No☐ Biphosphonates (Fosamax, Boniva) Yes☐ No☐

Do you now have, or have you had any of the following:

	Yes	No		Yes	No		Yes	No
1. Heart Disease	☐	☐	10. Arthritis	☐	☐	19. Tuberculosis	☐	☐
2. High Blood Pressure	☐	☐	11. Tumor History	☐	☐	20. Allergy to a) Penicillin	☐	☐
3. Blood Disease	☐	☐	12. Veneral Disease	☐	☐	b) Other Antibiotics	☐	☐
4. Rheumatic Fever	☐	☐	13.Artificial Joints	☐	☐	c) Local Anesthetics	☐	☐
5. Heart Murmur	☐	☐	14. Radiation	☐	☐	d) Latex	☐	☐
6. Mitral Valve Prolapse	☐	☐	15. Liver disease	☐	☐	e) other	☐	☐
7. Diabetes	☐	☐	16. Kidney Disease	☐	☐	21. Are you pregnant?	☐	☐
8. Stroke	☐	☐	17. Hepatitis	☐	☐	22. Any Major Operation	☐	☐
9. Epilepsy	☐	☐	18. Asthma	☐	☐	23. Aids or HIV positive	☐	☐

If yes to any of the above, Please explain:

_____

DENTAL HISTORY

How often do you: Brush?_____ Floss?_____

Have you ever been instructed in caring for your teeth/gums?_____

Have you ever had periodontal (gum) treatment? _____ When?_____

Are you aware of Grinding or Clenching your teeth?_____

Are you having any problems now? _____

Are you apprehensive about dental treatment?_____

Name of previous Dentist _____

When was your last: a) Dental Visit_____

b) Full Set of X-Rays_____

c) Cleaning_____

Remarks_____

_____

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient. I also agree to assume full financial responsibility for all treatment rendered and assign benefits to the treating dentist.

Patient's Signature_____ Date_____ Doctor's Signature_____

Medical Update_____ Date_____ Medical Update_____ Date_____

Medical Update_____ Date_____ Medical Update_____ Date_____

ASSIGNMENT AND RELEASE

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Keivan Khorshid, D.D.S./ABC Dental Care.

X _____ _____
Insurance Policy Holder / Subscriber Signature — Date

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third payers and/or other health practitioners.

X _____ _____
Signature of patient, parent if patient is a minor or legal guardian — Date

FINANCIAL POLICY

I understand that any information or benefits obtained in writing or verbal from my dental insurance carrier *is not a guarantee of coverage or eligibility* until the actual claim is submitted and process. I also understand that my dental insurance carrier may pay less than the actual amount estimated for services, Iagree to be responsible for payment of all services rendered on my behalf or dependents. All co-payments, deductibles and any percentages established by your insurance plan are due at the time of service.

We will gladly bill your insurance for you dental services, therefore, we require that you supply us with all appropriate information such as telephone numbers and addresses regarding your insurance carrier. In the event inaccurate information is obtained, making it impossible to bill the claim, the account will become your responsibility and payable in full with in 90 days of the billing statement. After 90 days an APR of 15%(1.25 monthly) will apply.

If your insurance carrier is Indemnity not a PPO plan and if it pays below our UCR (usual and customary rate), you are responsible for the balance they do not cover. Our office is committed to providing the best treatment for our patients and we charge what is usual and customary rates in our area. Your insurance policy is a contract between you and your insurance carrier. There is no contractual discount between ABC Dental Care and your insurance carrier.

If you have no insurance plan, full pay is expected at time of service. We accept cash, all major credit cards and checks with a valid drivers license. If any of this methods is not convenient for you, CareCredit is available on approved credit. CareCredit helps patients/applicants by making treatment more affordable with small monthly payments. Ask front desk for details.

In the case of default on payment on this account, I agree to pay any collection and reasonable attorney fees incurred in attempting to collect your outstanding account balance.

I understand that there is a $25.00 charge for any appointments cancelled the same day or without 24hr notice.

I have read, understand and agree to the statements in the financial policy.

X _____ _____
Signature of patient, parent if patient is a minor or legal guardian — Date

PATIENT CONSENT FORM

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.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 to obtain a current copy of the Notice of Privacy Practices.

I understand thatI 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

ABC Dental Care
General And Cosmetic Dental Professionals

7219 W. Sahara Ave., STE 130
Phone: 702-228-1700 FAX: 702-228-1776

Photo release form for social media

This Media Release Form is effective _____by _____

Who acknowledges and agrees to the terms below:

1. The Patient grants permission to ABC Dental Care to use his/her photographs on the company's social media accounts including Facebook, Instagram, Tik Tok and Twitter, and on the company website, without acknowledgement or recognition given to the patient.

2. The patient grants the company creative permission to alter the photographs, permitted that the photographs are not altered in an explicit manner or cause malicious representation of the patient and their associates.

3. The patient certifies that they are 21 years of age or older.

4. In giving this consent, the patient releases the company from liability for any violation of any personal or proprietary right the patient may have in connection with all third parties' use of the images on social media.

_____ _____

Authorized Signature Printed Name