Welcome!

We are committed to provide you with the best possible care and help you achieve your optimum oral health. To achieve these goals, we would like to explain our office policies.

PATIENT RESPONSIBILITIES

DENTAL BENEFIT PLANS: ***For your convenience we are a PPO Provider Practice***. Before moving on with your appointment please verify with the Front Office if we are In-Network with your insurance. Your Dental Benefit is a contract between YOU or YOUR EMPLOYER and the DENTAL BENEFIT PLAN. Benefits and payments received are based on the Terms of the contract negotiated between YOU or YOUR EMPLOYER and the BENEFIT PLAN.

If we **ARE** a Contracted Provider with your Benefit Plan, **YOU ARE RESPONSIBLE** for your portion of the approved fee as determined by your plan. We are **REQUIRED** to **COLLECT** the **Patient's Estimated Portion** (***ANY AMOUNT NOT COVERED BY THE DENTAL BENEFIT PLAN ex: CO-PAY, DEDUCTBLE, CO-INSURANCE***) in **FULL PAYMENT** at the time of Service**.** ***If we ARE NOT a Contracted Provider with your Benefit Plan, it is YOUR Full Responsibility to Pay the difference in Coverage.***

Please be advised that all financial estimates we provide are STRICTLY ESTIMATES, as we are not guaranteed anything we are told by insurance companies over the phone. There are also many provisions of insurance plans that we may not be aware of. Although we strive to obtain as much information about your insurance as possible, it is ultimately your responsibility to know what your insurance does and does not cover. After we receive final payment from your insurance, any difference between what was estimated and what was paid will be refunded or billed to you, accordingly.

PAYMENTS: Payments are ALWAYS due at the time of service.

Payment is due in full at the time of treatment unless prior arrangements have been approved. There is finance charges applied to accounts when they go without payments (1/month). We use a collecting agency after 11 months of no payments received with finance/late charges applied prior. You will be responsible for any charges incurred for legal or collection services.

APPOINTMENTS: We reserve the Doctor and Hygienist's time on the schedule for each patient procedure and are diligent about being On Time. For this reason, when a patient Cancels an appointment, it impacts the overall quality service we are able to provide. **Therefore, we require a 24hr notice to Re-Schedule or Cancel an Appointment.** With less than a 24hr Notice a Fee of ***$60.00*** will be applied. There is a grace period of 15 minutes if running late; passing that time will result in a ***Late Fee of $60.00***. We ask to be courteous about other patients and call in advance.

PPE: As you know, PPE has been a hot topic during pandemic. You might have heard the shortage, as well as the increase in cost. Companies from which we get our PPE's, have increased their price many times over, and we of course, need more of these PPE's, for the safety of everyone at the office. We charge $10 per patient, for this increase in cost. However, we want you to know that we also understand that these times can be difficult and challenging for many of our patients. Thus, if you do not want to be charged for this extra fee, please do let us know.

Please Sign below once you have Read and Understood Our Practice's Guidelines. Thank You.

X_____ Date_____

Protecting the Confidentiality of Your Health Information

It is our desire to communicate to you that we are taking the new Federal HIPAA (Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you delay treatment because you are concerned that your health history might be unnecessary made available to others outside of our office.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal Law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our variable patient.

We will use and communicate your Health Information ONLY for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented transferred, exchange, and/or used for non-healthcare related purpose including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment and for healthcare operations.

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request to inspect and/or receive a copy of your health information.
- You have the right to request an alternate means or location to receive communications regarding your health information.
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

****Conditions and limitations may apply. If needed, please ask the Front Desk for further information.****

Changes to this Notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an update notice will be posted and a copy will be sent to you.

CROWN DENTAL CARE – PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____ Mobile: _____ Work: _____

E-Mail Address: _____

What is your preferred method of contact?

[ ] Home [ ] Mobile Home [ ] Work Phone [ ] E-Mail

Social Security number: _____ Date of Birth: _____

Driver's License #: _____ State: _____ Sex: [ ] Female [ ] Male [ ] Nonbinary

Marital: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Dental Benefit Plan Information

Primary Dental Plan Name: _____

Name of Insured: _____ Insured D.O.B: _____ Subscriber I.D/Enrollee ID Number: _____

Policy Number/ Group Number: _____ Relationship to Insured: _____

Dental History Form

Former Dentist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Last Dental X-Rays: _____Date of Last Dental Visit: _____

Reason for Visit: _____

If you left your previous dentist, what was the reason? _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

At Home Oral Hygiene Care

How often do you brush your teeth? _____ How often do you floss? _____

Do you use mouthwash? Yes / No If Yes, which kind: _____

Do you use any other dental home care products? Yes / No If Yes, which kind: _____

Circle Appropriate Answer (Leave Blank if you do not understand the questions)

1. Are you currently experiencing dental pain or discomfort? Yes/ No
   If yes, explain:
2. Do your gums bleed? Yes/ No
   If yes, explain:
3. Are your teeth loose? Yes / No
   If yes, explain:
4. Do you wear dentures or partial? Yes / No
   If yes, explain:
5. Have you ever been told you have gum disease? Yes / No
   If yes, explain:
6. Are your teeth sensitive to hot, cold, sweets or pressure? Yes / No
   If yes, explain:
7. Have you ever had any clicking, popping or discomfort in the jaw? Yes / No
   If yes, explain:
8. Do you brux or grind your teeth? Yes / No
   If yes, explain:
9. Do you wear an occlusal guard? Yes / No
   If yes, explain:
10. Have you ever had orthodontic treatment (braces) before? Yes/ No
    If yes, explain:
11. Do you have any dry mouth? Yes / No
    If yes, explain:
12. Does Food or floss catch between your teeth? Yes/ No
    If yes, explain:
13. Have you had any problems or an upsetting dental experience associated with previous dental care? Yes/ No
    If yes, explain:
14. Are you fearful of dentistry or have anxiety associated with dental treatment? Yes / No
    If yes, explain:
15. Have you ever been pre-medicated for dental treatment? Yes/ No
    If yes, explain:
16. Have you ever had a reaction to anesthetic used with your dental treatment? Yes/ No
    If yes, explain:
17. Are you happy with your smile? Yes/ No
    If No, please explain:
18. What would you change about the present condition of your mouth?

19. Is there anything else you would like us to know about your dental healthy or dental history? Yes/ No
    If yes, explain:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____ _____

Signature of Patient (Parent or Guardian) Date

_____ _____

Signature of DDS/RDH – License # Date

Confidential Health History

I. Circle Appropriate Answer (Leave Blank if you do not understand the questions)

Is your general health good? Yes \ No
If No, explain:
_____

Has there been a change in your health within the last year? Yes \ No
If yes, explain:
_____
Have you gone to the hospital or emergency room or had a serious illness in the last three years? Yes \ No
If yes, explain:
_____

Are you being treated by a physician now? Yes \ No If yes explain: _____

Date of last medical exam? _____ Reason for exam? _____

Have you had problems with prior dental treatment? Yes \ No

If yes, explain? _____

Date of last dental exam: _____ Name of last treating dentist: _____

Are you in pain now? Yes \ No
If yes, explain? _____

II. Have you ever experienced any of the following? (Please Circle Yes or No for each)

Yes / No Chest Paint (angina)
Yes / No Fainting spells
Yes / No Recent significant weight loss
Yes / No Fever
Yes / No Night Sweats
Yes / No Persistent cough
Yes / No Coughing up blood
Yes / No Bleeding problems
Yes / No Blood in urine
Yes / No Blood in stools
Yes / No Diarrhea or constipation
Yes / No Frequent urination
Yes / No Difficulty urinating
Yes / No Ringing in ears
Yes / No Headaches
Yes / No Dizziness
Yes / No Blurred vision
Yes / No Bruise easily
Yes / No Frequent vomiting
Yes / No Jaundice
Yes / No Dry mouth
Yes / No Excessive thirst
Yes / No Difficulty swallowing
Yes / No Swollen ankles
Yes / No Joint pain or stiffness
Yes / No Shortness of breath
Yes / No Sinus problem
Other: _____

III. Have you ever experienced any of the following? (Please circle Yes or No for each)

Yes / No Heart Disease
Yes / No Family history of heart disease
Yes / No Heart attack
Yes / No Artificial joint
Yes / No Stomach problems or ulcers
Yes / No Heart defects
Yes / No Heart murmurs
Yes / No Rheumatic fever
Yes / No Skin disease
Yes / No Hardening of arteries
Yes / No High blood pressure
Yes / No Seizures
Yes / No Cosmetic surgery
Yes / No AIDS/HIV
Yes / No Surgeries
Yes / No Hospitalization
Yes / No Diabetes
Yes / No Family history of diabetes
Yes / No Tumors or cancer
Yes / No Chemotherapy
Yes / No Radiation
Yes / No Arthritis, rheumatism
Yes / No Emphysema or other lung disease
Yes / No Kidney or bladder disease
Yes / No Stroke
Yes / No Eating disorders
Yes / No Psychiatric care
Yes / No Osteoporosis
Yes / No Thyroid disease
Yes / No Asthma
Yes / No Hepatitis
Yes / No Sexual transmitted disease
Yes / No Herpes
Yes / No Canker or cold sores
Yes / No Anemia
Yes / No Liver disease
Yes / No Eye disease
Yes / No Transplants
Yes / No Tuberculosis

Other: _____

IV. Are you allergic to or have you had a reaction to any of the following? (Please circle Yes or No for each)

Yes/ No Aspirin
Yes/ No Penicillin or other antibiotics
Yes/ No Nitrous oxide
Yes/ No Valium or sedatives
Yes/ No Metal
Yes/ No Latex
Yes/ No Local anesthetic
Yes/ No Codeine or other opioids
Yes/ No Food
Others: _____

V. Are you taking or have you taken any of the following in the last three months? (Please circle Yes or No for each)

Yes / No Recreational drugs
Yes / No Over-the-counter medicines
Yes / No Weight loss medications
Yes / No Anti-Depressants
Yes / No Tobacco in any form
Yes / No Alcohol
Yes / No Bisphosphate (Fosamax)
Yes / No Herbal Supplements
Yes / No Antibiotics
Yes / No Supplements
Yes / No Aspirin
Opioids (e.g., Norco/Vicodin, Percocet, Percodan) If Yes, please explain reason: _____

_____

Please list all prescription medications: _____

VI. Vaccination: COVID-19 (Please circle Yes or No for each, and fill in dose dates)
Yes / No / Prefer not to answer > Moderna, Pfizer, Johnson & Johnson, Other: _____ 1. _____ 2. _____ 3. _____

VII. Women Only (Please circle Yes or No for each)
Yes / No Are you or could you be pregnant? If YES, what month? _____
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VIII. All Patients (Please circle Yes or No for each)
Yes / No Do you have or have you had any other disease or medical problems NOT listed on this form?
If YES, please explain:
_____
Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____
Yes / No Have you ever taken Fen-Phen? If YES, when: _____
Yes/ No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize Dr. Farahmand to contact my physician.

Patient's Signature: _____ Date: _____
Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?
Name: _____ Relationship: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any chance in my healthy and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____
Signature of Patient (Parent or Guardian) Date Signature of DDS/RDH – License # Date