****

**Patient Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If under 18 years old, Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_ Single \_\_ Married \_\_ Divorced \_\_ Widowed \_\_ Separated \_\_ Domestic Partner

**In Case of an Emergency:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\* How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental Insurance – Primary**

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_ Subscriber Birthday: \_\_\_\_\_\_\_\_\_

Subscriber SSN/ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Broken appointments:** A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we **require**at least 24 hours’ notice to avoid a $35.00/hour cancellation fee (emergencies are an exception).

**Assignment and Release**

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to **Zaki Dental** all insurance

benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges**

**whether paid by insurance or not**. I hereby authorize the doctor to release all information necessary to secure the payments of

benefits. I authorize the use of this signature on all insurance submissions.  
 **CONSENT:** I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.  
  
**Patient/Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tell Us About Yourself**

Your current **physical** health is: ❑ Good ❑ Fair ❑ Poor   
Your current **dental** health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No   
Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you like your smile? ❑ Yes ❑ No - If no what would you like to change? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any **cough, cold, flu/COVID19** like symptoms in the **last 48 hours**? ❑ Yes ❑ No

How can we accommodate you better during your dental visit?   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your last dental check up / exam was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are you in any dental related pain? ❑ Yes ❑ No Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco in any form? ❑ Yes ❑ No

**Have you had any metal rods, pins or implants placed NON DENTAL**? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑ No

**Please list each one: (if you have a list we can scan it)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking or have you taken any **bisphosphonates** **for** **osteoporosis** or any other medications for osteoporosis? ❑ Yes ❑ No Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any surgical procedures (Non-Dental)? ❑ Yes ❑ No

Please list each one: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Here at Zaki Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our staff to discuss with you during your visit.

**Tooth Whitening Veneers/Lumineers Invisalign Smile Makeover**

**Traditional Orthodontics (Brackets) Bonding Sealants**

**Crown and Bridge Implants Implant Crowns Partials/Dentures**

**Night/Sport Guards Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History**

Please check the box if you have or had any of these conditions.

|  |  |  |  |
| --- | --- | --- | --- |
| AIDS/ HIV Positive ❑  Alzheimer’s Disease ❑  Anaphylaxis ❑  Anemia ❑  Angina ❑  Arthritis/Gout ❑  Artificial Heart Valve ❑  Artificial Joint ❑  Asthma ❑  Blood Disease ❑  Blood Transfusion ❑  Breathing Problems ❑  Bruises Easily ❑  Cancer ❑  Chemotherapy ❑  Chest Pains ❑  Cold Sores/ Fever Blisters ❑  Congenital Heart Disorder ❑  Convulsions ❑ | Cortisone Medicine ❑  Diabetes ❑  Drug Addiction/Recovery ❑  Easily Winded ❑  Emphysema ❑  Epilepsy or Seizures ❑  Excessive Bleeding ❑  Excessive Thirst ❑  Fainting Spells/Dizziness ❑  Frequent Cough ❑  Frequent Diarrhea ❑  Frequent headaches ❑  Genital Herpes ❑  Glaucoma ❑  Hay Fever ❑  Heart Attack/Failure ❑ Heart Murmur ❑  Heart Pacemaker ❑  Heart Trouble/Disease ❑ | Hemophilia ❑  Hepatitis A ❑  Hepatitis B or C ❑  Herpes ❑  High Blood Pressure ❑  High Cholesterol ❑  Hives or Rash ❑  Hypoglycemia ❑  Irregular Heartbeat ❑  Kidney Problems ❑  Leukemia ❑  Liver Disease ❑  Low Blood Pressure ❑  Lung Disease ❑  Mitral Valve Prolapse ❑  Osteoporosis ❑  Pain in Jaw Joints ❑  Parathyroid Disease ❑  Psychiatric Care ❑ | Radiation ❑  Recent Weight Loss ❑  Renal Dialysis ❑  Rheumatic Fever ❑  Rheumatism ❑  Scarlet Fever ❑  Shingles ❑  Sickle Cell Disease ❑  Sinus Trouble ❑  Spina Bifida ❑  Stomach Disease ❑  Stroke ❑  Swelling of Limbs ❑  Thyroid Disease ❑  Tonsillitis ❑  Tuberculosis ❑  Tumors or Growths ❑  Ulcers ❑  Venereal Disease ❑  Yellow Jaundice ❑ |

**If you do not have any of the conditions above, please initial here: \_\_\_\_\_\_\_**

**Allergies (Circle) If Female, Please Answer**

|  |  |
| --- | --- |
| Aspirin Codeine Dental Anesthetics  Erythromycin Latex Metals    Penicillin Tetracycline Other: \_\_\_\_\_\_\_\_\_\_ | ❑ Are you taking Birth Control Pills?  ❑ Are you pregnant? If so, # of Weeks \_\_\_\_\_\_\_  ❑ Are you nursing? |

**Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT HIPAA CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy.

**What this is all about:**

Specifically, there are rules and restrictions on who may see or be notified

of your Protected Health Information (PHI). These restrictions do not include the normal

interchange of information necessary to provide you with office services. HIPAA provides

certain rights and protections to you as the patient. We balance these needs with our goal of

providing you with quality professional service and care. Additional information is available

from the U.S. Department of Health and Human Services. www.hhs.gov

**We have adopted the following policies:**

1. Patient information will be kept confidential except as is necessary to provide services or

to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other that office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient record, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes several vendors in the conduct of business. These vendors may have access the PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT TO PROCEED**

I authorize **Dr. Zaki and/or such associates, hygienists or assistants** as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects,

which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and

temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and

basic dentistry, including fillings of all types or crowns, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one’s mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental

instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed.

This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of nonhealing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name if parent/legal guardian or authorized agent of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_