PRESTIGE
FAMILY DENTAL
ANAS RAHIMO DDS

45700 Schoenherr Rd.
Shelby Twp. MI. 48315
(586**)** 932-2444

Patient Information

Patient Name:_____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____ Birth Date: _____

Social Security #:_____ Driver's License #:_____ State:_____

Phone (Home):_____ (Work):_____ Ext:_____ Best time to call: _____

(Cell)_____ E-Mail:_____ Fax: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Emergency Contact: _____
First & Last name Contact Number

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HEALTH INFORMATION

Previous Dentist:_____ Date of Last Dental Visit: _____

Reason for this visit: _____

- Are you currently under a physician's care now? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you ever had a serious head or neck injury? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you taking any medications, pills, or drugs? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No
- Are you on a special diet? ☐ Yes ☐ No
- Do you use tobacco? ☐ Yes ☐ No
- Do you use controlled substances? ☐ Yes ☐ No

Women - Are you:

Pregnant/Trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐Yes ☐No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain:_____.

Have you ever had any of the following? Please check those that apply:

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes, please explain:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date_____

Signature of patient, parent or guardian

_____ Date:_____

Signature of Doctor

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Cosmetic Information

Is there anything about your smile that you do not like?_____

Are you interested in knowing the options available for a more beautiful smile? _____

Do you like the appearance of your teeth?_____

Are all of your teeth in alignment (straight)?_____

Do you have any missing teeth?_____Are any chipped?_____

Is your bite comfortable when chewing, biting?_____

Do you have frequent headaches?_____

Do you have any old fillings or dental treatment that you are unhappy with?_____

What would you like to change the most about the appearance of your teeth?_____

Is there anything else that you would like us to know?_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another Doctor

☐ Dental Office ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for: ☐ Self ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #:_____Birth Date:_____Driver's License #: _____

Phone (Home):_____(Work):_____Ext:_____Best time to call: _____

Address: _____

Street Apartment # City State Zip Code

Please list people to whom we may release your medical information to: _____

_____

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Employment Information

The following is for the patient:

Employer Name:_____ Occupation:_____

Address: _____
Street City State Zip Code

Primary Dental Insurance Information

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date:_____ ID #:_____ Group #:_____ SS#:_____

Insured's Address: _____
Street City State

Insured's Employer Name:_____ Insurance Company: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Insurance Plan Name and Telephone: _____

Secondary Dental Insurance Information

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date:_____ ID #:_____ Group #:_____ SS#:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name:_____ Insurance Company: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Insurance Plan Name and Telephone: _____

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Our office will prepare and submit dental insurance forms on behalf of the patient. The patient will be responsible for all estimated copays and deductibles on the date of service. After payment from the insurance company we will bill the patient for any unpaid balances.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding forty five (45) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date:_____Relationship to Patient: _____
Signature of guarantor of payment/responsible party

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "ACKNOWLEDGMENT" TO ACKNOWLEDGE THAT YOU HAVE TODAY RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with:

1. A defense to a claim challenging our professional competence;
2. A review entity's functions;
3. A claim for payment of fee's;
4. A third party payers examination of our records;
5. A court order as a part of a criminal investigation;
6. An identification of a dead body;
7. A licensure investigation; or
8. A child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PLEASE SIGN THIS FORM BELOW UNDER THE HEADING "CONSENT" TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PATIENT ACKNOWLEDGMENT

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____
Patient/Guardian Signature

PATIENT CONSENT

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____
Patient/Guardian Signature

****

Office Use Only

_____Patient Refused to Sign
____The following circumstances prohibited the patient from signing the Acknowledgment:
_____
____
_____An emergency situation prevented the patient from signing the Acknowledgment.

_____ _____
Date_____
Office Personnel (signature) Office Personnel (print name)

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Prestige Family Dental

Dr. Anas Rahimo
586-932-2444

Office Financial Guidelines

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Guidelines which we require you read and sign prior to any treatment.

YOUR ESTIMATED PATIENT PORTION IS DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS
And CARE CREDIT

Dental Insurance: Understanding your insurance coverage can be quite a challenge. Our goal is to assist you in maximizing your insurance by filing the necessary forms so you can receive your full benefit. We do this as a courtesy to our patients because your insurance policy is between you and the insurance company. We make no guarantee of any estimated coverage due to changes in employment status or treatment at other dental or dental specialty offices. We care for patients from many different employers. Each company pays an insurance premium for specific coverage which fits the employer's budget. Each plan is different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

Minor Patients: The adult accompanying a minor and the parents (or guardian of the minors) are responsible for full payment. In a divorce situation, regardless of agreements between ex-spouses, the parent signing the health history form will ultimately be held responsible for the account and its payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre authorized to an approved Credit Plan, Credit Card, or payment by cash or check at time of service has been verified.

Missed Appointments: Please help us serve you & our family of patients better by keeping your reservation with our office. If an appointment needs to be changed, kindly give us 48 business hours in advance so that we may accommodate another patient if needed. ** All appointments must be confirmed or they will be removed from the schedule **

Our expectations of you:

1) Payment of fees not covered by your insurance plan at time of treatment.
2) Please understand that the insurance policy belongs to **<u>you</u>** and we have no leverage to obtain payment from your insurance carrier.
3) Realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called UCR) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, *not* our fees or recommended treatment.
4) You will have to take responsibility for any fees your insurance has not covered after 90 days. The balance on your account will be charged to your credit card.

I hereby authorize Prestige Family Dental to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Prestige Family Dental; I understand I am responsible for any unpaid balances. I understand that treatment cannot be completed until it is paid for (i.e. crowns will not be cemented, dentures will not be placed). I understand I am responsible for all charges associated with this account and that interest charges of 1.5% per month will accrue on unpaid balances and a statement charge of $5.00 will be added to subsequent statements. A $25.00 fee will be assessed for all returned checks.

Responsible Party Signature

_____ DATE _____

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Appointment Cancellation and No-Show Policy

Prestige Family Dental is privileged to provide dental treatment to our patients. We will work diligently to maintain a high level of personalized service and will strive to accommodate our patients' need for office visits in a timely manner. This requires careful planning and coordination among many individuals in our office.

We understand that emergencies arise from time to time, just as they do for us; however, when a patient fails an appointment or cancels without adequate notice, we cannot use that time to meet the needs of other patients. We respectfully request your understanding and agreement to our policy as it is stated below.

New Patients:

We will give you a reminder phone call within at least 48 hours of your scheduled appointment. New patients who fail or cancel initial appointments with less than 48 hours' notice prior to the appointment, will be required to pay a fee of $50 for a hygiene visit and $75 for a dentist visit before scheduling another appointment. For Monday appointments, cancellations must be made by noon on the preceding Friday. Cancellations may not be called into our answering service.

Established Patients:

Established patients who fail or cancel appointments with less than 48 hours' notice prior to the appointment, will receive a letter informing them of the missed appointment and a copy of our appointment policy. A second such occurrence will result in a $50 fee for missed hygiene visits and a $75 fee for missed dentist visits. Fees must be paid before rescheduling and only same-day scheduling will be permitted. A third such occurrence will result in dismissal from the practice.

For Monday appointments, cancelations must be made by noon on the preceding Friday. Cancellations may not be called into our answering service. The scheduling parent or scheduling legal guardian of minors who fail or cancel appointments with less than 48 hours' notice will be held responsible for the missed appointments.

Fees:

Fees charged by Prestige Family Dental pursuant to this policy are not payable by insurance companies.

All fees must be paid prior to your scheduling another appointment or within 30 days of a billing statement, whichever is earlier.

Your dentist may waive your fee for a good cause. To request your fee to be waived, you must email a written explanation to prestigefamilydental@gmail.com. Please enter your dentist's name in the subject line of the e-mail. If you do not have e-mail access, you may send a letter to our office.

Patient Signature Date _____ _____

Parent/Legal Guardian Signature _____