



AVDental
Associates PA

APPRECIATED PATIENT LETTER

Date. _____

To My Appreciated Patient. _____

This year marks the beginning of many exciting changes in my office in my effort to improve service and quality of care for you so that you can regain and maintain your health as quickly, efficiently, and inexpensively as possible.

I have a purpose - and that purpose is to get sick people well and to prevent the well from getting sick. I also have a personal, professional, and ethical responsibility to care for your health to the best of my ability. Missed appointments and failure to comply with recommended treatment schedules and/or procedures prevent me from achieving my goal of optimum health for you.

If you cannot keep your appointments and adhere to my treatment recommendations, I will not be able to continue treating you in good conscience.

Therefore, the following policies must be agreed upon:

1. No-shows are not acceptable. Failure to make an appointment not only compromises your health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot make an appointment (except in the case of an emergency) you are expected to call within 48 hours of your appointment to reschedule. There is a \$50.00 fee for all no-show appointments per hour and this fee is not covered by insurance. This money will be matched by CLIENT NAME and donated to St. Jude's Children's Hospital.
2. Timeliness is required. We will see you on time and get you out on time unless there is an emergency. We request that you be on time for your visits. If you are more than 10 minutes late, you may have to reschedule your appointment.
3. Cleanliness and infection control are of the utmost importance. We have the - latest sterilization technology and disinfect each treatment room after every patient. This is another important reason we demand timeliness of you and ourselves. We request that you brush your teeth prior to being seated in a treatment room. Toothbrushes, paste, mouth rinse, and floss will be provided for you if needed.
4. If you miss an appointment you must make it up. It is critical to your health to do so to avoid setbacks in the care and maintenance of your teeth and gums.
5. Insurance: Treatment recommendations are based on your health not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well being - we are. We will provide you with an estimate of benefits; however you are fully responsible for any treatment performed. Your benefits are a contract between you and your insurance company. We cannot be responsible for what your insurance will or will not cover.
6. We run a Zero Balance office. We expect payment in full prior to or at the time treatment is provided. We have several financial options available for all of our patients. Please speak to (designated team member) if you have any questions.
7. In order to schedule an appointment with DR. Arash Vahid, we require 50% of the total patient out-of-pocket expense as a deposit and a signed financial agreement.
8. Our policy is to make your experience in our office an exceptional one. When we succeed, we would appreciate you telling your family and friends about our office.
9. Upsets: It is our company policy to ensure the complete satisfaction of all of our patients with the service and care they receive at our office. However, it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to make things right by you should an upset occur provided you bring it to our attention in an appropriate, cordial manner and at a time that we can give the matter the proper attention it deserves for effective resolution. You can expect that my staff will treat you with the same professional demeanor and efficiency, as you would expect from them. Please see our office manager to resolve immediately any upsets you may have with my office or one of my team.
10. Emergencies: It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency we want you to be assured that we will take care of you. In order to do this we would like to define what a true emergency is. Swelling, bleeding, severe pain that has kept you up at night or requires medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these symptoms we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergencies.

I greatly appreciate your cooperation.

Yours in Health, Dr. Arash Vahid

(Patient Signature)

(Office Signature)



Patient Information

Date _____

SS/HIC/Patient ID# _____

Patient Name _____
Last Name

_____ First Name Middle Name

Address _____

Email _____

City _____

State _____ Zip _____

Sex M F Age _____

Birth date _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone _____

Spouse's Name _____

Birth date _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to patient _____

Insurance co. _____

Group# _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birth date _____

SS# _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to _____
Name of Insurance company(ies)

Dr. _____ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian, or Personal Representative

Please print name of Patient, Parent, Guardian, or Personal Representative

Date

Relationship to Patient

Phone Numbers

Home _____ Work _____ Ext. _____ Cell phone _____

Spouse's Work _____ Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who doesn't live in your household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Dental History

Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dentist visit _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-Ray _____	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you had any of the following:	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to hear <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in the mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Loose teeth or broken <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____



Health History

Physician's Name _____ Date of Last visit _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin, (brand names of phentermine), Pondimin (lenfluramine) and Redux (dexfenluramine) Yes No

Place a mark on "yes" or "no" to indicate if you had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or Growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

Medications

Allergies

List any medications you are currently taking and the correlating diagnosis.

Pharmacy Name _____

Phone _____

Aspirin

Local Anaesthetic

Barbiturates (sleeping pills)

Penicillin

Iodine

Other _____

Latex

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



Patient acknowledgements of Receipt of Privacy Practices Notice

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

I also understand that if I have any question or complaints, I may contact:

You may also contact the secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature _____ Date _____

Name _____

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgement of _____ receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (Check all that apply):

- Patient refused to sign (date of refusal) _____
- Communication barriers prohibited obtaining an acknowledgement.
- An emergency situation prevented us from obtaining an acknowledgement.
- Other _____

Attempt was made by: _____ Date _____