ENERGY DENTAL
Laya Omarian, DDS

Patient Information

First Name: _____ Last Name:_____ M.I: _____

Phone:_____ D/O/B: _____ SS#: _____ DL#:_____

Address: _____City: _____ State: ____ Zip: _____

Email: _____ Sex: Male / Female

Marital Status: _____ Employment Status: _____

Responsible Party

First Name: _____ Last Name:_____ M.I: _____

Phone:_____ D/O/B: _____ SS#: _____ DL#:_____

Address: _____City: _____ State: ____ Zip: _____

Email: _____ Sex: Male / Female

Marital Status: _____ Employment Status: _____

Primary Insurance Information

Name of Insured: _____ D/O/B: _____

Insured SS#:_____Relationship: ___Self ___Spouse ___Child Other

Employer: _____ Address: _____

Ins. Company: _____ Member ID: _____

Health History

(Circle if any apply)

HIV Positive	Cortisone Medicine	Hepatitis	Arthritis
Alzheimer's Disease	Diabetes	Rheumatism	Excessive Bleeding
Anaphylaxis	Herpes	Artificial Heart Valve	Dizziness
Anemia	High Blood Pressure	Artificial Joint	Frequent Cough
Emphysema	Shingles	Asthma	Stroke
Epilepsy	Sick Cell Disease	Blood Disease	Tuberculosis
Hives	Sinus Trouble	Leukemia	Heart Disease
Hypoglycemia	Blood Transfusions	Liver Disease	Other: _____
Irregular Heartbeat	Frequent Headaches	Cancer	_____
Kidney Problems	Low Blood Pressure	Chemotherapy	_____
Breathing Problems	High Blood Pressure	Osteoporosis	
Lung Disease	Thyroid Disease	Tumors or growths	
Chest Pain	Heart Attack/Failure	Radiation	
Heart Murmur	Pain in Jaw Joints	Recent Weight Loss	
Pacemaker	Ulcers	Renal Dialysis	
Psychiatric Care	Hemophilia	Angina	

Please describe if you circled any of the options above:

_____

_____

Are you allergic to any medication? If yes: _____

Are you allergic to any of the following? ___Aspirin ___Penicillin ___Latex ___Other

Do you use tobacco? Yes / No Are you currently taking any medications? Yes / No

If yes, please list:

_____

_____

Are you under care of a primary physician? Yes / No

Primary Care Physician: _____

Contact Number: _____ Last Visit Date: _____

Patient Name: _____ Date: _____

Patient Signature: _____

Guardian Name: _____ Date:_____

Guardian Signature: _____

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WRITTEN FINANCIAL POLICY

Thank you for choosing Energy Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

For patients <u>without</u> dental insurance, all payments are due at the time services are started. Payment options stated below.

Payment Options:

Accepted payment options:

- Cash
- Credit (MasterCard, Visa, Discover, Amex)
- Care Credit
- Alphaeon
- Lending Club

For patients with dental insurance, claims will be submitted to your insurances provider for your convenience. Our system allows us to <u>estimate</u> the portion of your services they may cover. <u>You, the patient/responsible party, are liable for any amount of your rendered treatment that is not covered by your insurance.</u>

Any balance more than 30 days old is expected to be paid in full regardless of insurance status.

By signing below you are acknowledging Energy Dental's financial policy.

Patient Name: _____ Date: _____

Patient Signature: _____

Guardian Name: _____ Date: _____

Guardian Signature: _____

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AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing this form, you acknowledge that you have received a copy of the Notice of Privacy Practices. This Notice explains how your health information will handle HIPAA, the federal law concerning medical privacy, requires this notice.

Patient Name: _____

Patient Signature: _____ Date: _____

Guardian Name: _____

Guardian Signature: _____ Date: _____

Providers Use of Policy

If patient was not able to sign due to an emergency, or chose not to sign, please document if patient was given the notice and the reason why the patient did not sign below:

Patient was given the notice but was refused: _____

Reason signature was not obtained:

_____

_____

Staff Signature: _____ Date: _____

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CANCELLATION POLICY

We reserve the right to charge for any appointment(s) broken without 48 hours' notice. The charge will be $50 per appointment. These fees are not covered by insurance and are the sole responsibility of the patient. Fees must be paid in full prior to the patient's next appointment and are non-refundable.

- Cancellations or changes require notice two business days prior to your appointment date
- Our voice mail is available for messages left after business hours
- Appointments on Tuesdays must be confirmed by Friday at 12pm, otherwise it is subject to cancellation without notice.

We understand that extreme/unavoidable emergencies or circumstances do arise which may require you to cancel your appointment, and individual circumstances will be taken into consideration.

Thank you for your cooperation!

By signing below you are acknowledging Energy Dental's cancellation policy

Patient Name: _____

Patient Signature: _____ Date: _____

Guardian Name: _____

Guardian Signature: _____ Date: _____

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HIPAA COMPLIANCE PATIENT CONSENT

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Patient Name: _____

Patient Signature: _____ Date: _____

Guardian Name: _____

Guardian Signature: _____ Date: _____