Please Read Before Filling Out Forms…

We appreciate your interest in our dental practice. You have probably noticed we are different from the average dental practice. When you visit our office you will find a unique and relaxing environment. Our treatments are designed to be painless, permanent and to exceed your expectations. We use the most recent technology and techniques our industry has to offer. Our biggest strength lies not only in the quality of our work, but in how you are treated as well.

Essentially, we are "three different offices" in one facility.

- **General Dentistry:** These are the services a patient would expect to see in an average dental office such as cleanings and fillings. We excel in this area by providing comfortable, permanent and predictable services.

- **Cosmetic Dentistry:** All dentists proclaim to offer "cosmetic services" but we have taken it to a new level. We use the best materials and techniques available to get the best results. We offer a complete range of procedures from whitening/bleaching to veneers and implants.

- **Functional Dentistry:** Also called neuromuscular dentistry (NMD). This assesses a patient's bite (how the upper and lower teeth fit together) and diagnoses any malfunction. Some common symptoms of a "bad bite" are jaw pain/soreness/stiffness, grinding of teeth, headaches, jaw clicking/popping/locking, and chipped/broken teeth. Correcting the bite helps the jaw stay in the proper position for optimal function and comfort. A more functional bite can even improve your appearance, smooth wrinkles and make you look younger.

When a patient allows us to combine all 3 areas of dentistry, we achieve the best results. Filling out the following questionnaire will help us understand what areas you are interested in. We are only here to show you what the possibilities are. The extent of treatment you receive whether it's all, some or none is always entirely your choice.

Today's Date ___________________________

Name ____ Date of Birth _________________________

Address ____

Home Phone _____________________ Work Phone _____________________ Cell Phone _____________________

Our office is not just an average dental office. We place a high emphasis on providing you with the very best care possible, the highest quality materials and most advanced techniques in dentistry for your present and future dental needs. Here are some things we'll be talking about at your first visit. These are issues you may not have considered before. Please take a few moments to think about and answer the following questions:

Are you having any areas of concern?____ __________

Do you have any family or friends that already come to our office?____

What do you already know about our office and what are your expectations? _______________________________________

____

Tell us, in your opinion, what you think the present state of the health of your mouth is?

____

How do you feel about the appearance of your face and smile? ____

How healthy do you want us to get your mouth? (please circle)

"Don't really care" Average The best it can be

Should you need treatment, at what point should we address it? (please circle)

When my tooth hurts or breaks When something is worsening When something isn't ideal

What quality of dentistry do you want us to recommend? (please circle)

"Just patch it" Average Ideal/the best

We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? (please circle)

As a general dentist As a cosmetic dentist As a functional dentist

Tell us about your good dental experiences… ____

and the bad ones… ____

What caused you to leave your last dentist? ____

What would help you to trust us as your dental office? ____

____

Has either time or fear ever been a factor in getting your dental work done? ____ Time ____ Fear

Is the cost of dental treatment a concern for you?_________

Did you know our office can help you obtain financing?______ Would you like to know more about this option? _______

Is there any additional information you would like us to know? ____

REVIVE NEUROMUSCULAR & COSMETIC DENTISTRY

PATIENT INFORMATION

Last Name ______________________________ First Name _____________________________ Middle ____________________

❑ Male ❑ Female ❑ Single ❑ Married (Spouse's Name ______________________) ❑ Other _________________

Date of Birth ____________________________ Social Security # __________________________

Address ____ City/State _______________________________ Zip________________

Home Phone _____________________ Cell Phone _____________________ Email ___________________________________

Emergency Contact _______________________________________ Relationship to Patient _______________________________

Emergency Phone Number__________________________________ Alternate Phone Number _____________________________

EMPLOYMENT

Employer Name ____ Occupation _________________________________

Address ____ City/State ________________________________ Zip_______________

Work Phone _______________________ Ext. __________

How did you find out about us? ❑ Another Patient, friend* ❑ Another Patient, relative* ❑ Dental office* ❑ Doctor office*

❑ Internet/Website ❑ Radio ❑ Magazine ❑ Foxhall Square Walk-in ❑ A New Me ❑ Yellow Pages

* Whom may we thank for referring you to our office? ____

HEALTH HISTORY

Are you taking any medication now, including regular dosages of aspirin? ❑ Yes ❑ No

If yes, please list name and dosage____

Are you allergic to any medication or substance? ❑ Yes ❑ No If yes, please list _______________________________________

Indicate which of the following you have had, or have at present

____ AIDS/HIV
____ Anemia
____ Arthritis
____ Artificial Heart Valve
____ Artificial Joints
____ Asthma
____ Bell's Palsy
____ Blood Disease
____ Cancer
____ Clenching Jaw
____ Congenital Heart Disease
____ Depression
____ Deviation of Jaw to one side
____ Diabetes
____ Difficulty Chewing
____ Difficulty Swallowing
____ Ear Congestion
____ Epilepsy/Seizures
____ Excessive Bleeding
____ Facial Pain
____ Fainting
____ Glaucoma
____ Grinding Teeth
____ Growths
____ Heart Concerns
____ Heart Disease
____ Heart Murmur
____ Headaches
____ Hepatitis
____ High Blood Pressure
____ Insomnia/Frequent Waking
____ Jaw Clicking/ Popping
____ Jaw Locking
____ Jaw Joint Pain
____ Kidney Disease
____ Latex Sensitivity
____ Limited Jaw Movement
____ Limited Jaw Opening
____ Liver Disease/Jaundice
____ Loose Teeth
____ Lupus
____ Mitral Valve Prolapse
____ Mental Disorder
____ Multiple Sclerosis
____ Neck/Shoulder Pain
____ Nervous/Anxiety Disorder
____ Neurological Disorders
____ Pacemaker
____ Pain Behind Eyes
____ Posture Problems
____ Radiation/Chemotherapy
____ Ringing or Pain in Ears
____ Respiratory Problems
____ Rheumatic Fever
____ Rheumatism
____ Sensitive Teeth
____ Sickle Cell Disease
____ Sinus Problems
____ Stomach Problems
____ Stroke
____ Thyroid Disorder
____ Tingling in Arms/Fingers
____ Trigeminal Neuralgia
____ Tuberculosis
____ Tumors
____ Ulcers
____ Uncomfortable Bite (feels "off")
____ Visual Disturbances
____ Venereal Disease
____ Vertigo (Dizziness)
____ Worn or Cracked Teeth

Do you have or have you had any disease, condition or problem that was not listed? ____

____

Have you been admitted to a hospital or needed emergency care within the past two years? ❑ Yes ❑ No

If yes, for what?____

Have you been under the care of a medical doctor within the past two years? ❑ Yes ❑ No

If yes, for what? ____

Physician's Name ____ Phone #____________________________

Have you seen an ENT (ear, nose & throat doctor)? ❑ Yes ❑ No Chiropractor? ❑ Yes ❑ No Neurologist? ❑ Yes ❑ No

Have you had Cortisone therapy? ❑ Yes ❑ No If yes, when?______________ For how long?____________ Dosage __________

Have you ever had any cosmetic procedure(s)? ❑ Yes ❑ No If yes, please list?____

Women: Are you Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

DENTAL HISTORY

When was your last dental visit? __________________ What was done at that time? ____

Reason for **this** visit ____

Have you ever had any complications following dental treatment? ❑ Yes ❑ No If yes, please explain ___________________________

____

How often do you brush your teeth? ____________________ How often do you floss? _____________________

Do your gums bleed while brushing? ❑ Yes ❑ No Do your gums bleed while flossing? ❑ Yes ❑ No

Do your gums feel tender or swollen? ❑ Yes ❑ No Does floss shred when you use it? ❑ Yes ❑ No

Do you avoid brushing any part of your mouth because of pain? ❑ Yes ❑ No If yes, what part? ______________________________

Do you feel sensitivity or twinges of pain when your teeth come in contact with:

a) hot foods or liquids like soup, coffee or tea? ❑ Yes ❑ No

b) cold foods or liquids like ice cream or cold water? ❑ Yes ❑ No

c) sweets such as candy, fruit or sweet desserts? ❑ Yes ❑ No

d) sours like lemons, limes, grapefruit, etc.? ❑ Yes ❑ No

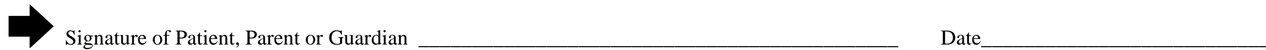
Do you clench or grind your jaw while sleeping or during the day? ❑ Yes ❑ No Does your jaw ever feel tired? ❑ Yes ❑ No

Do you lose or break fillings? ❑ Yes ❑ No Have you had braces? ❑ Yes ❑ No

Does your breath concern you? ❑ Yes ❑ No Do you smoke or chew tobacco? ❑ Yes ❑ No

Are you familiar with the term "preventive" dentistry? ❑ Yes ❑ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, all of the answers and information provided are true and correct. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. If I ever have any change in my health or medication, I will inform Dr. Yazdani at the next appointment without fail.



Signature of Patient, Parent or Guardian ____ Date________________________

CONSENT FOR SERVICES

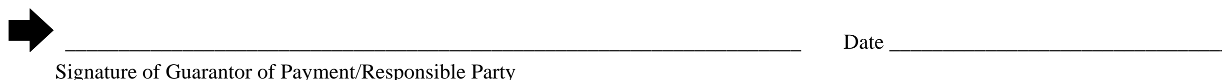
As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed. All fee estimates are valid only for a period of 6 months from the date of the exam or consultation.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office does not render services on the assumption that our charges will be paid by an insurance company. Any account with an unpaid balance exceeding 60 days will incur a service charge of 1 ½% per month (18% per annum) unless previous written financial arrangements were made.

In consideration for the services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his/her assignee, at the time said services are rendered, or within 5 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be 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.

I grant my permission to the Doctor or his/her assignee to telephone me at home or at my work to discuss matters related to this form.

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



____ Date ____________________________

Signature of Guarantor of Payment/Responsible Party

Revive Neuromuscular & Cosmetic Dentistry

Financial & Payment Policy

We are committed to providing you with the very best care possible, the highest quality materials and most advanced techniques in dentistry. If you have dental insurance we will attempt to maximize your benefits. In order to achieve this goal, we will need **your** cooperation by providing us with the proper insurance information at the time of your appointment as well as learning about your dental plan's coverage and exclusions. **Please understand that your insurance is a contract between you and your insurance company. Certain procedures and services may not be covered by your insurance** and you are ultimately responsible for your bill, regardless of the amount of insurance reimbursement.

Payments for Preventive and Basic procedures are due at the time of service, while payment for Major procedures must be made prior to the start of treatment. As a courtesy service, our office will assist you with submitting your insurance claims so that you may receive reimbursement checks directly from your insurance company.

We accept **MasterCard, Visa, American Express** and **cash** for payment of services. We also offer assistance with obtaining dental financing, some of which can be interest-free depending on the cost of treatment and type of payment plan selected.

Personal checks are accepted from established patients only. There will be a $50.00 fee for any returned checks and a $100.00 fee for any cancelled checks. We will file a Warrant-In-Debt with the District of Columbia Federal Court for any returned or cancelled checks not re-paid within five business days.

Any account balance exceeding 30 days without payment arrangements will incur a late fee at the rate of 1.5 % every month until the balance is paid in full. Any account balance that exceeds 90 days or more will be sent to collections. If your account is sent to collection, you will be responsible for all collection and /or attorneys' fees and court costs.

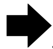
Please remember that all appointments are exclusively reserved for you. Please respect this reservation by giving us 48-hours advanced notice for any appointment you need to cancel. Failure to notify us within 48 hours of your scheduled appointment will result in a missed appointment charge of $150.00. If you miss more than one scheduled appointment you will be asked to secure the reservation of future appointments with a credit card. Also, if you arrive more than 15 minutes late your appointment will need to be rescheduled as it is unfair to keep the next patient waiting to be seen.

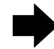
As a courtesy service we will do our best to make reminder/confirmation calls prior to appointments, but please understand that this is not always possible and it is your responsibility to remember appointment dates and times.

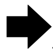
In accordance with District of Columbia law and HIPPA regulation (see 45 C.F.R. § 164.524) **our office is required to maintain all original X-ray films**, however, copies of your X-ray films can be made. **A $50.00 duplication fee applies per set.**

We look forward to serving you with all of your dental needs and appreciate your understanding and cooperation.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES, AND AGREE TO ACCEPT THE RESPONSIBILITIES AS DESCRIBED ABOVE.

 ______________________________ Signature

 ______________ Date

 ______________________________ Printed Name

REVIVE NEUROMUSCULAR & COSMETIC DENTISTRY

NOTICE OF PRIVACY PRACTICES & CONSENT FORM

Patient's Name ____ Phone ____________________________

Address ____

Please read the following statements carefully:

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment.

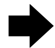
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by request in person or by contacting our office via telephone, fax or email.

CONSENT

I, ____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

 **Patient's Signature** ____ **Date** __________________

If this Consent is signed by a Personal Representative on behalf of the patient, complete the following:

________________________________	________________________________	______________________________
Representative's Name	Representative's Signature	Relationship to Patient

REVOCATION OF CONSENT

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action taken in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

Patient's Signature ____ Date ______________________

You are entitled to a copy of this Consent after you sign it