



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

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

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 1/2% 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

REVOCAION 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