Dr. Narjes Abtahi DDS

Patient's Name_____ Social Security #_____

Gender _____ Birthdate_____ Email Address_____

Home Address _____City _____ State_____ Zip_____

Home Phone _____ Cell Phone _____

Emergency Contact Name _____ Phone Number _____

Primary Pharmacy Name & Location _____ Phone Number _____

How did you hear about our office?

(Please select all that apply)

YAHOO! ☐ Google ☐ bing ☐ ***A Friend (name):*** _____ ***or other:*** _____

As a courtesy, we will remind you of every appointment you have scheduled with our office. Please circle which method of contact you prefer to receive your reminder.

Phone call/Voicemail Text Email

Office Policy

Thank you for choosing Your Community Smile as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, MasterCard, Visa, Discover, American Express, and Care Credit. Outstanding financing (payment plans) is available upon request and approval.

Please Note: Returned checks will be subject to additional fees. In the care, it becomes necessary for our service to enlist a collection of service and/ or legal assistance, you will be responsible for any collection and/or legal charges up to 35%

- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not guaranteed that your insurance will pay exactly as estimated. Any part of your bill not covered by your insurance or denied payment will be your responsibility.
- Upon scheduling an appointment for dental treatment, a deposit of 50% is required. This deposit is not refundable & can only be used towards your dental treatments.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationships with you, our patient, not your insurance company. Your insurance policy is contract among you, and your employer, and your insurance company. Our office is not a party to that contract.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, MasterCard, Visa, Discover, American Express, or Care Credit at the time we provide the service to you.
- Insurance Payments are ordinarily received within 30-60 days of the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will file up to one dispute for any denied claim for each date of service in which services are rendered to you.

Consent: I _____, have read, understood, and agreed to the terms and conditions listed above.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care of our financial policy.

CONSENT: I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge, and/or attorney fee will be added to any overdue balance.

CONSENT: I authorize Your Community Smile and its' staff to take X-Rays and Photos to aid in diagnosis and/or for my treatment.
By signing below, you are authorizing us to call you and/or email you at any number/email you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an upcoming call from us, and/or outgoing calls to us, to or from and such number, without reimbursement from us.

Patient and/or Guardian Signature: _____ **Date:** _____

Missed Appointment / Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. To be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when its missed, that time cannot be used to treat another patient. We ask that you give our office 48 hours' notice (if calling on a day that the office is closed, a voicemail with your name and appointment date and time is required to properly cancel) if you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment time. If you miss an appointment without contacting our office within the required time or do not show up for your appointment, this is considered a missed appointment. A fee of $60.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled no can records be transferred without the payment of this fee. Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $60.00 cancellation fee will be charged. After missing three appointments with or without notice, you may be placed on a same day scheduling policy for treatments, which would not allow you to schedule any appointments in advance. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

Please initial amongst the following lines below

_____ I understand that If I am unable to keep my appointment I am required to call at least 48 hours prior to my given appointment time to avoid a missed appointment fee of $60.00 (excluding holidays)

_____ I understand that late cancellations, no shows, and late arrivals after 20 minutes will result in a missed appointment fee of $60.00.

_____ I understand that I am responsible of all missed appointment fees are my full financial responsibility and that my insurance company is not responsible for / will not pay for any missed appointment fees in which I incur.

_____ I understand that if I contact Your Community Smile in regard to cancelling my appointment before the 48-hour cut off time and I am not able to speak with a front desk coordinator, I will leave a voicemail in regard to cancelling my appointment to ensure proper cancellation.

_____ I understand that after missing and/or cancelling 3 appointments, I may be placed on a same day scheduling policy for treatments. Which would not allow me to schedule any appointments in advance.

_____ I understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice

Signing below indicates that you understand and agree to the terms of this policy

_____ _____

Signature of Patient Date

DENTAL & MEDICAL HISTORY

☐Y☐N Are you currently having dental discomfort? If yes, explain: .....
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

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The most important concerns regarding your dental visit today is:

.....

☐Y☐N Are you currently required to pre-medicate prior to receiving dental treatment? If Yes, Explain:
☐Y☐N Under physicians care now? If Yes, Explain: .....
☐Y☐N Any hospitalization in the past 5 years? .....
☐Y☐N Any serious illnesses/surgeries? If Yes, Explain:
☐Y☐N Are you currently taking any medications, drugs, or pills? If Yes, Explain:
☐Y☐N Use tobacco and/or use a vape? If Yes, Explain:

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: .....

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

.....

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY) IF NONE, CHECK "NONE":

☐NONE

☐ALLERGIES (SEASONAL)
☐ALCOHOLISM
☐ANGINA (CHEST PAIN)
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐AUTO-IMMUNE DISEASE
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ALZHEIMER'S DISEASE
☐ASTHMA
☐BLOODY SPUTRUM
☐BACTERIAL ENDOCARDITIS
☐BRUISE EASILY
☐CANCER
☐CERVICAL CANCER
☐CONGENITAL HEART DISORDER
☐CHEMOTHERAPY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐CONVULSIONS
☐DRUG DEPENDENCY
☐DIARRHEA (FREQUENT)
☐DIABETES
☐DIZZINESS/FAINTING
☐EXCESSIVE THIRST
☐EPILEPSY/SEIZURES
☐EXCESSIVE BLEEDING
☐FREQUENT HEADACHES
☐GENITAL HERPES
☐GLAUCOMA
☐HEARING PROBLEMS
☐HEMOPHILIA
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HAY FEVER
☐HEPATITIS A / B / C
☐HYPOGLYCEMIA
☐IRREGULAR HEART BEAT
☐KIDNEY DISEASE
☐LIVER DISEASE
☐MITRAL VALVE PROLAPSE
☐ORAL HERPES/FEVER BLISTERS
☐PARATHYROID DISEASE
☐PACEMAKER
☐RAPID WEIGHT GAIN/LOSS
☐**OTHER – PLEASE LIST:**
☐RESPIRATORY DISEASE
☐RECENT BLOOD TRANSFUSION
☐RHEUMATIC FEVER
☐RENAL DIALYSIS
☐STOMACH PROBLEMS
☐SLEEP APNEA
☐SINUS PROBLEMS
☐SICKLE CELL DISEASE
☐SHORTNESS OF BREATH
☐STROKE
☐THYROID DISEASE
☐TUBERCULOSIS
☐ULCERS/COLITIS
☐VENEREAL DISEASE
☐HIGH BLOOD PRESSURE

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ALL PATIENTS: ARE YOU **ALLERGIC** TO OR HAVE YOU EVER HAD ANY REACTION TO ANY MEDICATIONS? (IF YES, PLEASE EXPLAIN):

Patient Signature: _____ Date: _____ Dentist Signature: _____