ABOUT YOU

Today's Date:_____

Name: _____ I prefer to be called: _____ ❑Male ❑Female
Last First MI MR MRS MS DR

Birthdate: ____/____/____ Age: _____ Social Security #: _____ ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Home Address: _____
Street City State Zip

Home Phone #: (____)_____ Cell #: (____)_____ Work Phone #: (____)_____ Ext.____ Driver License #: _____

Where & when are the best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____ Email: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/P.O. Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relationship: _____ Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relationship: _____ Home Phone #: (____)_____ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext:____ Driver's License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate ____/____/____ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext:____ Driver's License #: _____

INSURANCE INFORMATION

Primary Insurance Medical Coverage? ❑Yes ❑No Dental Coverage? ❑Yes ❑No Orthodontic Coverage? ❑Yes ❑No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy#): _____

Insurance Co. Address: _____
Street/P.O. Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate ____/____/____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/P.O. Box City State Zip

Secondary Insurance Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy#): _____

Insurance Co. Address: _____
Street/P.O. Box City State Zip

Insured's Name: _____ Insured's Social Security #: _____ Insured's Birthdate ____/____/____ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/P.O. Box City State Zip

TERMS & CONDITIONS

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 costs 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 service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. Additionally, I 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 you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed: _____ **Date:** _____

PLEASE COMPLETE BOTH SIDES!

DENTAL HISTORY

Have you experienced problems associated with previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? _____

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

If yes, why? _____

Previous / Present Dentist: _____ Date last visit: _____

Why did you leave your previous dentist? _____

What did you like most & least about any dentist you have seen? _____

Are you happy with the way your smile looks? ❑ Yes ❑ No

If no, what would you change? _____

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street City State Zip

Phone #: (____)_____ Date of last visit: _____

Your current physical health? ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Sedatives
Y N Barbiturates	Y N Jewelry / Metals	Y N Sulfa Drugs
Y N Codeine	Y N Latex	Y N Tetracycline
Y N Dental Anesthetics	Y N Penicillin	Y N Other

Please list any additional drugs/materials that cause allergic rections: _____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Insulin/Diabetes Drugs	Y N Thyroid Medicine	Y N Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates
Y N Antibiotics	Y N Blood Pressure Medication	Y N Nitroglycerin	Y N Tranquilizers	
Y N Antihistamines	Y N Cold Remedies	Y N Recreational Drugs	Y N Phen-Fen	
Y N Aspirin	Y N Digitalis/Heart Medication	Y N Steroids/Cortisone		

Are you taking any prescription/over-the-counter-drugs not listed above? ❑ Yes ❑ No If yes, please list each one: _____

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenial Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fever Blisters	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized for Any Reason	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: _____

I understand a 24-hour notice is necessary for canceled appointments. There will be a $50.00 charge for appointments missed as the result of the office not being notified 24 hours prior to the scheduled appointment.

Year 1

Date _____ Signature _____

Changes in health Yes or No

Year 2

Date _____ Initials _____ ❑ Yes ❑ No

Year 3

Date _____ Initials _____ ❑ Yes ❑ No

Year 4

Date _____ Initials _____ ❑ Yes ❑ No

Year 5

Date _____ Initials _____ ❑ Yes ❑ No

Year 6

Date _____ Initials _____ ❑ Yes ❑ No

	Year 1	Year 2	Year 3
Date			
By			
	Year 4	**Year 5**	**Year 6**
Date			
By			

DO NOT WRITE IN THIS SPACE

Health Questionnaire MUST be updated every year!

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be _____

Signature Date

PAYMENT DUE AT TIME OF SERVICE

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature Date

Hani A. Nasr, DDS
5260 FRANCIS AVE | CHINO CA, 91710 | (909) 627-7452

Written Financial Policy

Thank you for choosing Hani A. Nasr, DDS. 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.

Payment Options:

You can choose from:

- Cash, Visa®, MasterCard®, American Express® or Discover Card®

  We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with Cash prior to completion of care for treatment plans of $1000 or more.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Hani A. Nasr, DDS requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds. For plans requiring multiple appointments, alternative payment arrangements may be provided.

We also offer in-house financing.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $50 is charged for patients who miss or cancel more than 3 times in a calendar year without 24-hour notice.

Hani A. Nasr, DDS charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 120 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.