TADROS
:DENTISTRY

Patient Information

Patient Name: First____________________MI__________Last_______________________________

Address: Street _______________________________City _______________State ______Zip _______

Phone: Home _____________________ Cell______________________ Text ok? ☐Yes ☐No

Social Security Number ____________________________Date of Birth: / /

Business Address ______________________City __________________State________Zip_______

Business Phone______________________

Sex ☐Male ☐Female **Marital Status** ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Email:________________________________

In case of emergency, who should be notified?

Name ____Home Phone _______________________

Cell Phone ___________________________Business Email________________

Primary Insurance

Subscriber's Name____ **Birthdate / /**

Relationship to Patient____________________________ **Soc. Sec.**___________________________

Address (if different from patient) :

Street____________________________________City____________________State ____Zip _______

Phone: Home _______________________________ Cell___________________________

Subscriber employed by: ______________________________

Business Email: ______________________________________

Insurance Company_________________________ Phone ____________________________

Contract# ____________________Group #________________________Subscriber's#_____________

Name(s) of other dependents under this plan ____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber's Name____ **Birthdate / /**

Relationship to Patient____________________________ **Soc. Sec.**___________________________

Address(if different from patient) :

Street____________________________________City____________________State ____Zip _______

Phone: Home _______________________________ Cell___________________________

Subscriber employed by: ______________________________

Business Email:_______________________________________

Insurance Company_________________________ Phone ____________________________

Contract# ____________________Group #________________________Subscriber's#_____________

Name(s) of other dependents under this plan ____

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Are you in dental discomfort today?____

What would you like us to do today?____

Date of last dental care ____________________ **Date of last X rays** ____________________

Check Y for Yes or N for no if you have or have not had the following

	Y	N		Y	N
Are your teeth sensitive to Heat?			Do you have problems with your jaw?		
Cold?			Clicking of the Jaw?		
Sweets?			Jaw Pain (joints, ear, side of face)?		
Biting Pressure?			Difficulty Chewing?		
Does food catch between your teeth?			Have you ever had a reaction to anesthetic? Describe:		
Bleeding gums			Tobacco habit		
Bad breath			Sores or growth in mouth		
Have you ever had a “deep” cleaning?			Have you had any ORAL CANCER?		

Medical History

Physician’s name_______________________________Adress______________________________

Date of last visit / Physician’s email____

Have you had any serious illness or operation? ☐Y ☐ N If yes Describe:_____________________

Have you blood transfusion? ☐ Y ☐ N If yes give approximate date:____________

Have you ever taken Fen/Phen/Redux

Check Y for Yes or N for no if you have or have not had the following

	Y	N		Y	N
Herpes			Asthma		
Artificial heart valves			Diabetes		
Epilepsy			Fainting		
Cough up blood			Heart murmur		
Glaucoma			Spina Fidia		
Headaches			Heart problems		
Food allergies			Hepatitis A B C (please circle)		
Hemophilia/Abnormal bleeding			High blood pressure		
Kidney disease or inflammation			HIV Positive		
Artificial joints			Radiation treatment		
Arthritis			Rapid weight gain or loss		
Anemia			Respiratory Disease		
Anaphylaxis			Rheumatic fever		
Atopic (allergy prone)			Scarlet fever		
Blood Disease			Shingles		
Back problems			Shortness of Breath		
Chemical dependency			Skin rash		
Chemotherapy			Do you or have bisphonates I.e. Fosamax?		

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	Y	N		Y	N
Cough persistent			Stroke		
Circulatory problems			Surgical Implant		
Cortisone treatments			Swelling of feet or ankles		
Cancer			Thyroid		
Liver disease			Tonsillitis		
Material allergies (latex, wool, metal, chemicals)			Tuberculosis		
Food allergies?			Tuberculosis		
Nervous problems			Ulcer/Colitis:		
Pace Maker/Heart Surgery			Venereal disease		
Psychiatric care			Women: Are you pregnant? Nursing? Or Taking Birth Control Medications?		
Mitral Valve prolapse					

List drug or dental anesthetic allergies____

____

List medications you are currently taking ____

____

Dentist Name: **Sameeh G Tadros DDS**

Signature ____Date_______________________________

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by dentists to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____Date_______________________________

Payment is due in full at time of treatment unless prior arrangements have been approved.

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Notice of Privacy Practices

How your Health Information may be used…

…To Provide Treatment

We will use your PHI inside our office to provide you with the best dental care possible! This may include office and clerical procedures used to streamline coordination between the Doctor, his Assistants, Hygienists, and business office staff. In addition, your treatment may require us to share your PHI with other entities such as referring Doctors, Clinical Laboratories, or your pharmacy.

…To Obtain Payment

We may include your PHI with paperwork sent to collect payment for the services you receive in our office, such as with insurance forms sent either through the mail or electronically. We will be sure to only work with companies with a similar commitment to the protection of your PHI.

…To Conduct Dental Care Operations

Your PHI may be used during performance reviews or training of our staff. It is possible your PHI would be disclosed during audits by insurance companies or government agencies as a part of their quality assurance or compliance reviews. Your PHI may be reviewed in the process of certification, licensing, or credentialing.

…In Patient Reminders

Because we believe regular care is very important to your dental health, we will remind you of an appointment you've scheduled or that it is time to contact us and make an appointment. Additionally, we may contact you to follow up on your treatment or to inform you of treatment options that may be available for you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best possible preventative, restorative, and cosmetic treatment modern dentistry can provide. This may include postcards, folding postcards, letters, voicemail messages, and electronic reminders such as e-mail (unless you tell us that you do not want to receive these reminders).

…Abuse or Neglect

We will notify the proper government agency if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we are specifically required or authorized by law or with the patient's agreement.

...Public Health or National Security

We may be required to disclose PHI to federal officials or military authorities when it is necessary to complete an investigation related to public health or national security.

…For Law Enforcement

We may be required to disclose PHI to a law enforcement official for law enforcement purposes. An example would be if you are a victim of a crime or in order to report a crime.

…Family, Friends, and Caregivers

With your permission, we may share your PHI with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. If there is an emergency, and you are unable to tell us what you want, we will use our very best judgment in sharing your PHI, and only when it will be important to those participating in providing your care.

…To Coroners, Funeral Directors, and Medical Examiners

We may be required by law to provide PHI to coroners, funeral directors, or medical examiners in order to determine a cause of death or prepare for a funeral.

…Research

Advances in dental knowledge often involve learning from the careful study of the dental histories of prior patients. Formal review of dental histories as a part of a research study will happen only under the ethical guidance of an Institutional Review Board.

Your Rights as a Patient

You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. You have the right to inspect and copy your PHI. You have the right to amend your PHI. You have the right to receive an accounting of disclosures of PHI. You have the right to obtain a paper copy of this notice from us upon request.

Name:

Date of Birth:

Date:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature:

X____

TADROS Dentistry OFFICE POLICY

Welcome to TADROS Dentistry! Our interest is to provide our patients with the finest possible, dental care. As your provider, we advise treatment that is in the best interest of your medical and dental health. Be aware, often, insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs. Following is an overview of our office financial policy we provide to you as a courtesy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. ***As a courtesy***, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement.

Initials_____

Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays. Initials_____

Copyright: Any comment posted online in any way relating to North Stapley Dental Care, doctors or employees will be the sole right and property of North Stapley Dental Care P.C. and the copyright of the content of the comment, rating, or review is hereby assigned to North Stapley Dental Care P.C. to utilize at our discretion in order to protect the practice and our patient's anonymity and privacy Initials_____.

Payment: Payment in full is required at the time of service. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, Mastercard, Discover, and American Express. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through Care Credit Initials _____

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary Initials_____

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in North Stapley Dental Care being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs Initials____.

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of $50.00 Initials_____.

Assignment of Benefit: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to North Stapley Dental Care.
I have read, understand, and agree to the above.

Name:____________________ Date:

Signature of Person Responsible for Account _________________________

PATIENT CONSENT TO TREATMENT

A. In reading and signing this form it is understood that ENGLISH is the language that I understand and to use to communicate. X--------(Initials)

1. **DRUGS, MEDICATION, AND ANESTHIA:**

- I understand that antibiotics, analgecis, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.
- I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty-four [24] hours after my release from surgery). I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation to the area of injection.
- I understand that if I select or utilize Nitrous Oxide, "Atarax", Chloryl hydrate, "Zanax", or any other sedative possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway. X-----------(Initials)

2. **HYGIENE AND PERIDONTICS (TISSUE AND BONE LOSS):**

- I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular call visits. X-----------(Initials)

PERIODONTICS- I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replaced and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction. X----------(Initials)

3. **REMOVAL OF TEETH:**

- I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time. Potential risks include, but are not limited to, the following:

A. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring prescriptions or additional treatment i.e. surgery).

B. Injury to adjacent teeth, caps, or fillings (requiring the recementation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area.

C. Limitation of opening; stiffness of facial and/or network neck muscles; change in bite; or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery).

D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needles surgical complications.

E. Possible bone fracture which may require wiring or surgical treatment.

F. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, check, teeth, and/or tongue on the operated side; this may persist for several weeks, months, or, in remote instances, permanently.

H. I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.
If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from these now contemplated, I request and authorize the doctor to do whatever (s)he may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

X---------(Initials)

4. **FILLINGS:**

- I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with the fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and built-up, and crowns), which would necessitate a separate charge.
- I understand that the silver amalgam restoration is an acceptable procedure to the American Dental Association guidelines and, such as, is a treatment used by Tadros Dentistry Centers. The advantages and disadvantages of alternate materials have been explained to me. X---------(Initials)

- 5. **ENDODONTIC TREATMENT (ROOT CANAL THERAPY):**

The purpose and method of root canal therapy have been explained to, me as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over a tooth. I understand the treatment risks can include, but are not limited to the following:

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.

B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
C. Infection.
D. Restricted jaw opening.
E. Breakage of root canal instruments during treatment, which may in the judgment of the doctor be left in the treated root canal or bone as part of the filling material, or it may require surgery for removal.
F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
G. Risk of temporary or permanent numbness in treatment area.
I. If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss. If failure or root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted. X--------(Initials)

[ ] 6. **CROWNS AND BRIDGE (CAPS):**

- I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy,
- I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment. X--------(Initials)

[ ] 7. **DENTURES- COMPLETE OR PARTIAL:**

The problem of wearing dentures has been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori [bone] removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction. X--------(Initials)

[ ] 8. **PERDONTICS (CHILD DENTISTRY):**

I understand that the following procedures are routinely used at Tadros Dentistry Services, as well as being accepted procedures in the dental profession.

A. POSITIVE REINFORCEMENT- Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or hug, and/or token objects or toys.
B. VOICE CONTROL- The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. PHYSICAL RESTRAINT- Restraining the child's disruptive movement by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special device (referred to as a "papoose board").
D. NITROUS OXIDE AND/OR ORAL SEDATION- Nitrous Oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over a child's nose. Oral sedation is medications administered to children to help them relax. With their use the parent/or guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth area for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

X------ (Initials)

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CUATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.
I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.
I UNDERSTAND THAT TADROS DENTISTRY PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARTIAL STATUS AND PROTECTS THE PRIVACY OF EACH IT'S PATIENTS.
Signature:_________________________ Relationship:______________ Date:_____________
Patient or Legal Representative
Doctor:_____________________________ Witness:__________________________