Smile Masters Dental-Implant Institute

Kass Nourishad, DDS, DICOI & Associates
Diplomate International Congress of Oral Implantology

REGISTRATION AND TREATMENT

Date_____ Home Phone (_____)_____

Cell Phone (_____) _____

PATIENT INFORMATION

Name_____ SS/HIC/Patient ID #_____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School_____ Occupation _____

Employer/School Address _____ Employer/School Phone (_____) _____

Whom may we thank for referring you? _____ How were you referred to us? _____

In case of emergency who should be notified? _____ Phone (_____)_____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient_____ Birthdate _____ ID#/Soc. Sec. # _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____

Contract # _____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____ Relation to Patient _____ Birthdate_____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (_____)_____

Insurance Company_____ Soc. Sec. #_____

Contract # _____ Group #_____ Subscriber #_____

Names of other dependents covered under this plan _____

Please Complete Above Information and Next Page

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist_____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia	☐ Cortisone Treatments	☐ Hepatitis	☐ Scarlet Fever
☐ Arthritis, Rheumatism	☐ Cough, Persistent	☐ High Blood Pressure	☐ Shortness of Breath
☐ Artificial Heart Valves	☐ Cough up Blood	☐ HIV/AIDS	☐ Skin Rash
☐ Artificial Joints	☐ Diabetes	☐ Jaw Pain	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Swelling of Feet or Ankles
☐ Back Problems	☐ Fainting	☐ Liver Disease	☐ Thyroid Problems
☐ Blood Disease	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tobacco Habit
☐ Cancer	☐ Headaches	☐ Pacemaker	☐ Tonsillitis
☐ Chemical Dependency	☐ Heart Murmur	☐ Radiation Treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Heart Problems	☐ Respiratory Disease	☐ Ulcer
☐ Circulatory Problems	☐ Hemophilia	☐ Rheumatic Fever	☐ Venereal Disease

MEDICATIONS
List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. Nourishad or Smile Masters Dental Implant Institute all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I will be charged interest and held responsible for any collection or legal charges on unpaid balances.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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

Our Office Policy

The following policies are designed to provide you with the best quality of care.
Effective immediately, the following policies are being implemented.

1. **FAILED, CANCELLED, RESCHEDULED APPOINTMENTS:**
   There is a charge of $25.00 for each and every failed appointment for exams and cleanings and a $ 50.00 charge for each treatment appointment. Any missed appointment is considered failed if our office does not receive 48 hour advanced notice.

2. **LATE APPOINTMENTS:**
   Please arrive on time so we can attend to you and give you the most amount of quality time. If you are 15 minutes late we will reschedule you, and you will be considered a failed appointment. We attempt to stay on time as best as possible. However, trying to accommodate late patients only makes the waiting time longer. Please be respectful to you fellow patients.

Please keep your appointments and be on time!

We hope that none of these circumstances will pertain to you and that you will help us to make this office feel like family. We only want the best results for you.

Financing

We offer financing through Care Credit. Once we have spent time with you to detail the needed treatment, assist you with the financing documents, detailing the terms of financing within your means, and satisfactions, we start our pre-treatment diagnostic procedure, which includes photos, models, wax up, and Doctor's time for analyzing and treatment planning. Therefore, we reserve the right to charge ten percent of the financed amount plus the cost incurred per models and preliminary lab work, upon any demand for cancellation of the contract before the beginning of the treatment.

Sincerely,
Dr. Kass Nourishad
Dr. Amir Dadgar
Dr. Micael Hilario
& Staff

I understand and acknowledge this office policy. I understand that the fees will be placed on my account and that I can be sent to collections for any overdue payments.

_____
Patients Name

_____ _____
Patient Signature/ Responsible Party Date