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
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ 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
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ 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.

Office Policy: First Dental Implant Center. Welcome.

1. Cancellation or No-Show Appointments: A $50 charge will be applied, in compliance with California law regarding reasonable cancellation fees.

2.Arrival Time: Patients are encouraged to arrive 15 minutes early for appointments.

2. Refund Policy: Pursuant to California law, once the agreement is signed, or third-party financial arrangements (such as Lending Club or Care Credit) have been made, or diagnostic impressions have been taken, no refunds will be issued. After the treatment agreement, extensive lab work is initiated, making refunds unfeasible. Any disputes must be resolved through the arbitration process, as agreed upon.

3. Social Media Etiquette: Patients are reminded not to discuss private office matters on platforms like Yelp or Google. In the event of a negative review, patients may choose to voluntarily waive certain rights under HIPAA to allow us to respond appropriately. However, patients have the option to decline this waiver, and their privacy rights under HIPAA will otherwise be upheld.

If you choose to waive your HIPAA rights for the purpose of responding to a negative review, please indicate your consent by checking the box provided below. If you do not wish to waive your HIPAA rights, please leave the box unchecked.

[ ] I voluntarily waive my rights under HIPAA to allow First Dental Implant Center to respond to negative reviews. [ ] I choose not to waive my rights under HIPAA.

Please note that the decision to waive HIPAA rights is entirely voluntary and will not affect your access to treatment or the quality of care provided.

By signing below, I acknowledge that I have read and understood the office policy of First Dental Implant Center, and I agree to abide by its terms.

Patient Name: _____

Signature: _____

Date: _____