WELCOME TO TADROS DENTAL! Please help us get to know you better by providing all the following information.

First Name: _____

Last Name: _____

Preferred Name: _____

Address: _____

_____

City: _____

State/Zip: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Other #: _____

Sex: O Male O Female

Marital Status: _____

Birth Date: _____ Age: _____

Social Security #: _____

Driver License #: _____

E-mail Address: _____

I respond to: O e-mails O texts

Primary Insurance

Policy Holder: _____

Relationship to Patient: _____

Subscriber DOB: _____ SSN/ID: _____

Employer: _____

Insurance Company Name: _____

Insurance Address: _____

Insurance Phone: _____ Group #: _____

Secondary Insurance:

How did you find out about Tadros Dental?

☐ Dr. Magdy Tadros ☐ Dr. Sheriev Boctor ☐ Dr. Sameh Aziz ☐ Saw Outside Sign

☐ Online Search ☐ Insurance Company ☐ Other: _____

I, or my dependent, assign directly to Tadros Dental 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 hereby authorize Tadros Dental to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

☆ Responsible Party Name: _____ Relation to Patient: _____

☆ Signature: _____ Date: _____

Consent: I consent and give Tadros Dental and its staff full permission to perform all procedures necessary for the proper diagnosis and treatment as seen appropriate for proper dental care.

☆ Patient/Guardian Signature: _____

TADROS DENTAL

Medical History

Conditions of the mouth are related to the whole body. Many diseases of the body are also related to diseases of the mouth and treatment may be changed or affected based on medication you are taking.
Please help us know more about your health by providing the following information.

Are you under a physician's care now? O Yes O No For What? _____

Have you ever had a serious head or neck injury? O Yes O No Details: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? O Yes O No If yes, please explain: _____

Do you use tobacco? O Yes O No Frequency/amount: _____

Do you use recreational drugs or controlled substances? O Yes O No If yes, please explain: _____

Women Only: Are you Pregnant/Trying to get pregnant? O Yes O No Number of Weeks: _____
Taking Birth Control Pills? O Yes O No Nursing? O Yes O No

Are you allergic to:

O Penicillin O Latex O Local Anesthetics O Codeine O Acrylic O Metal O Sulfa
O Other (give details): _____

Do you have, or have you had any of the following:

AIDS/HIV	OYes	ONo	Cortisone Medicine	OYes	ONo				Radiation Treatments	OYes	ONo
			Diabetes	OYes	ONo	Hepatitis A	OYes	ONo			
Anaphylaxis	OYes	ONo	Drug Addiction	OYes	ONo	Hepatitis B or C	OYes	ONo	Renal Dialysis	OYes	ONo
						Herpes	OYes	ONo	Rheumatic Fever	OYes	ONo
Angina	OYes	ONo	Emphysema	OYes	ONo	High Blood Pressure	OYes	ONo			
			Epilepsy or Seizures	OYes	ONo						
Artificial Heart Valve	OYes	ONo	Excessive Bleeding	OYes	ONo				Shingles	OYes	ONo
Artificial Joint	OYes	ONo				Hypoglycemia	OYes	ONo			
Asthma	OYes	ONo	Fainting Spells/Dizziness	OYes	ONo	Irregular Heartbeat	OYes	ONo			
Blood Disease	OYes	ONo				Kidney Problems	OYes	ONo			
Breathing Problem	OYes	ONo	Frequent Headaches	OYes	ONo	Liver Disease	OYes	ONo	Stroke	OYes	ONo
Bruise Easily	OYes	ONo				Low Blood Pressure	OYes	ONo			
Cancer	OYes	ONo				Lung Disease	OYes	ONo			
Chemotherapy	OYes	ONo				Mitral Valve Prolapse	OYes	ONo			
Chest Pains	OYes	ONo	Heart Attack/Failure	OYes	ONo	Osteoporosis	OYes	ONo	Tuberculosis	OYes	ONo
Cold Sores/Fever Blister	OYes	ONo	Heart Murmur	OYes	ONo				Tumors or Growths	OYes	ONo
Congenital Heart Disorder	OYes	ONo	Heart Pacemaker	OYes	ONo				Ulcers	OYes	ONo
Convulsions	OYes	ONo				Psychiatric Care	OYes	ONo			

Have you ever had any serious illness not listed above? _____

List medications you take and reasons for taking them:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health and can cause serious consequences and a potential of heart attack and death during or after treatment. It is my responsibility to inform the dental office of any changes in my medical status from now on.

☆ Signature: _____ Date: _____

TADROS DENTAL

Dental History

How may we help you today? _____

Are you currently in pain? O Yes O No For _____ days

Do you require antibiotics before treatment? O Yes O No Details: _____

You perceive your current dental health as: O Good O Fair O Poor

Do you have pain in Jaw joint or muscles? O Yes O No

Do you like your smile? O Yes O No why? _____

What would you like to change about your teeth and smile (color, shape, position, etc)

_____

How frequently do you brush/floss? Brush _____ Floss _____

Do your gums bleed? O Yes O No

Are your teeth sensitive to: O Cold O Hot O Chewing O Sweets

How do you feel about going to the dentist? O Love it O Doesn't bother me O Hate it

What do you dislike the most about dental visits? _____

How can we better accommodate you during visits? _____

When was your last: Visit to the Dentist: _____ Cleaning _____

Why did you leave previous dentist? _____

Do you believe you suffer from any of the following? (circle choices)

Bad Breath	Broken Teeth / Fillings	Periodontitis ("bone disease")
Lost Fillings or Crowns	Gum Disease	Cavities
Teeth Grinding/Clinching		

Here at Tadros Dental, we offer many services to keep your mouth and teeth healthy and your smile beautiful. Please circle any services below that you would like us to discuss with you:

Tooth Whitening	Veneers	Cosmetic Bonding
Replace Silver Fillings	Crowns & Bridges	Implant Crowns
Sealants	Partials & Dentures	Sports / Night Guards
Replace Missing Teeth	Reshaping Teeth	

What do you look for in a dental office?

Finances	State-of-Art Equipment	Relationship with Dental Team
Quality of Care	Weekend Appointments	Relaxed Environment
Knowledgeable Staff	Same-Day-Appointments	

Practice & Financial Policy

THANK YOU FOR CHOOSING TADROS DENTAL AS YOUR DENTAL CARE PROVIDER!

Dr. Mina and staff members are dedicated to serving your dental needs with the best professional advice, care and services obtainable. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to **read and sign prior to any treatment**. We are glad that you are here and we want to do our very best for you!

PRIVATE PAY PATIENTS:

Full payment is due at the time of service. We accept Visa, MasterCard, Discover, American Express and CareCredit. Please see our Patient Coordinator for more information on payment plan options.

INSURANCE PLANS:

Our office will gladly work with you to help get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore you will be expected to pay your deductible and ***estimated*** co-payment on the day services are rendered. **Filing insurance claims is a service we provide free of charge, but in no way relieves you from the responsibility of your bill.** If insurance pays less than the estimated portion, it is your responsibility to pay the difference. If for any reason your insurance company has not paid their estimated portion within 60 days from the start of treatment, you are responsible for payment in full at that time. You are responsible for advising our office if you have a change in your insurance coverage prior to your appointment. Please see our patient coordinator for payment plan options.

ISSED APPOINTMENTS:

We respectfully ask that you give us a minimum of 48 hours notice to cancel or reschedule your appointment. Please help us serve you better by keeping scheduled appointments. Failure to do so will result in a cancelation fee applied to your account.

I understand and agree to this financial policy. I have read the financial policy and agree that a photocopy of it shall be considered as effective and valid as the original. I also understand that regardless of my current insurance coverage, I am ultimately responsible for the timely payment of my account and I hereby authorize the payment of insurance benefits to be made directly to Tadros Dental, P.A. I understand that the fee for non-sufficient fund check is $35. I understand that treatment could be altered if my dental needs change.

I acknowledge the above Practice & Financial Policy and understand that I am fully responsible for my bill.

☆ Patient Signature: _____ Date: _____

If you would like your dental conditions and or appointment information to be discussed with your family members please list their names below:

1. _____
2. _____
3. _____
4. _____

HIPPA Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographics, that may identify you and that relates to your past, present or future physical, dental or mental health condition and related health care services.

1. Uses and Disclosures of PHI: Your PHI may be used and disclosed by your physician, dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We will also disclose to a family member, spouse, adult children, and information as necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons to the extent necessary to help with your healthcare and/or with payment for your healthcare. For example: when we would need to share your records of information to a specialist or a physician to whom you have been referred to, to ensure that the physician or specialist has the necessary information to diagnose or treat you.

Payment: Your PHI will be used as needed to obtain payment for your dental care services, including from your family members or friends. For example: obtaining approval for a dental procedure from an insurance carrier that may require that your relevant PHI be disclosed to the insurance plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose your PHI in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your PHI as necessary to contact you to remind you of your appointment via mail or by phone.

We may use or disclose your PHI in the following situations without your authorization: These situations include: as Required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements.

You have the right to inspect and copy your PHI: Under federal law, you may not inspect or copy information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI: This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. We will not retaliate against you for filing a complaint.

This notice was published and became affected on April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number 281-664-2244.

☆ I, _____, have received a copy of the above Notice of Privacy Practices from this office and give my permission to all of the above.

☆ _____ Date: _____

Signature

You may refuse to sign this acknowledgement

If refusing: _____ Date: _____