E Z Dental

Rachelle A. Ezzi, D.M.D.

Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____ **Home Phone (_____)** _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) ID#/Soc. Sec. # _____

Address _____ Mobile Phone: _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Whom may we thank for referring you? _____

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 _____

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 a "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 authorize my insurance company to pay to the dentist or dental group 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.

Assignment and Release

I, the undersigned, have insurance with _____
(name of insurance company)
and assign directly to E Z DENTAL all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by my insurance. I hereby authorize the doctor 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.

_____ _____
date signature

Financial Agreement

By avoiding billing costs we can offer our patients quality dentistry at affordable prices. In order to maintain these fees we request that payment is to be made at the time of service, unless other arrangements have been made in advance.
I agree that patient/parents/guardians are responsible for all fees and services rendered for treatment of patient/minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
date signature (patient/parent/guardian)

Minor/ Child Consent

I, being the parent or guardian of _____
(name of minor/child)
do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
date signature of parent or guardian

A MINIMUM CHARGE WILL BE MADE FOR FAILED OR CANCELLED APPOINTMENTS WITHOUT 24 HOUR NOTICE

Receipt of Notice Privacy Act (HIPPA)

Signature: _____ **Date:** _____

EZ DENTAL Office Policies

Thank you for choosing our practice for your dental care and oral health needs.

Our policies are intended to help provide you with quality dental care and personalized attention. For your safety, please inform us of any changes to your health or prescribed medications before your visit.

As a courtesy to our clients we accept assignment from your insurance carrier and will bill directly to them for you. Payment for your portion is due at the time of treatment. For procedures involving a laboratory component a deposit will be required when treatment is started. We offer payment by Visa, MasterCard, Debit and Cash for your convenience.

We are an amalgam-free office and use tooth colored (white) composite filling material for direct restorations. Some insurance carriers will not cover the cost of "white fillings" and will pay the amount charged for amalgam. If this happens you are responsible to pay the difference which will depend on the extent of the filling required.

We accept most dental plans and we will utilize the plan to maximize your benefits. However, we prefer to prescribe the best dental treatment for each client regardless of the participation of the dental plan. We encourage you to be completely familiar with the terms of your dental insurance plan. This is a contract between you and your dental insurance. With your approval pre-determination of insurance benefits can be obtained in advance from your insurance company by our office. The amount settled by the insurance company may be affected by such facts as annual limits of coverage, non-covered procedures, etc. Each company carries a different plan and this makes it extremely difficult for us to be aware of each and every plan detail. We will do our best to assist you with your plan when at all possible, but it is important to understand that *you are ultimately responsible for your payment of any treatment.*

If you find that you are unable to keep your scheduled appointment you are required two business days (48 hours) notice so that we may accommodate the dental; needs of other patients. A charge of $50.00 per hour of dental hygienist's time will be applied to your account, if we do not receive the 2 business days' notice to change your appointment time.

Your signature below indicates that you have read and understood the above and are aware of the policies in our office.

Signature_____ Date_____