PATIENT INFORMATION

First Name: _____ MI: _____ Last:_____

Nick Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

DOB: _____ ❑ Male ❑ Female SS#:_____

Address: _____ City: _____ State: _____ Zip: _____

Employer_____ ID/Driver's License #: _____

E-mail Address: _____

In case of Emergency/ Contact: _____ Relationship:_____ Phone: _____

How did you hear about our office?_____

RESPONSIBLE PARTY: Full Name: _____ DOB: _____ SSN#: _____

Street Address: _____ City: _____ State: _____ Zip: _____ Home Phone:_____ Work phone:_____ Employer Name:_____

INSURANCE INFORMATION: Primary Insurance: Primary Insurance Name:

_____

Address: _____ Phone Number: _____

Name of Insured: _____ Relationship: _____ ID Number: _____Group number:_____

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept most dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar. **.**

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference. All material fees, surgical fees, downgrades and other adjunctive services are not billed to insurance and patient is responsible.
- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - Payment Information: o All major credit cards are accepted (Visa, MasterCard, Discover and American Express)
- Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge.

Short Cancelled/ Missed Appointments

- **Please give 48-24 hours' notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you. - **Short canceled or missed appointments** will be charged $75.

-Do you consent to electronic communications (including email and text message)

Yes or No Signature_____ Date_____

By signing below I acknowledge I have read and understand the guidelines above.

Signature:_____ Date:_____

I acknowledge having received a copy of the Practice's Notice of Privacy Practices; I agree that a photocopy of this authorization is as valid as the original.

Signature: _____ Date: _____

Dental History

Are you having discomfort at this time? _____

How long since your last visit to a dentist? _____

What was done then? _____

Did you have x-rays? _____

How often do you visit a dentist? _____

Have you lost any teeth, including wisdom teeth? _____ When? _____

Why? _____

Have you ever had root canal treatment? _____

Are your teeth sensitive to: heat cold sweet sour

Have you had your teeth straightened? _____ When? _____

How often do you brush your teeth? _____

Do you use dental floss? _____ How often? _____

Do you have bleeding gums? _____

Do you grind or clench your teeth? _____ When? _____

Do you have any popping or clicking noises when you chew? _____

Have you ever had gum treatments? _____ When? _____

Do you have an unpleasant taste in your mouth? _____

Are you aware of any swelling or lumps in your mouth? _____

Do you have any fear of having dentistry done? _____

Why? _____

Do you feel good about your teeth? _____

Would you prefer to keep your natural teeth for your lifetime? _____

Does the idea of dentures displease you? _____

Does the appearance of your teeth affect your personal or business dealings?

_____

Do you feel that your smile is attractive? _____

Are you interested in knowing how your smile can be improved? _____

Any additional comments: _____

_____

_____

Time 8:13 AM | Kabani Dental, LLC | Date 12/3/2018

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

KABANI DENTAL
Cosmetic & Family

PHOTO CONSENT FORM

I hereby give Kabani Dental, and any and all employees and/or agents of Kabani Dental, the right and permission to use and/or publish photographs in teaching materials used to provide dental continuing education. I acknowledge Dr.Kabani the right to crop or otherwise treat the photograph at his/her discretion. I also acknowledge that the doctor may choose not to use my photographs at this time, but may do so at their own discretion at a later date. I also understand that once my image I posted on a web site, any computer user, which is beyond the control of Dr. Kabani, can download the image and I will hold her and any of her affiliated offices harmless from any such use or download

I hereby freely and voluntarily consent to the use of my photograph and testimonial as stated above until I revoke this consent in writing

Initial the following:

_____Yes, you may use my photos.

_____No, please do not use my photos.

_____

Name of Patient or Parent/Guardian (Please Print)

_____

Patient or Parent/Guardian (Signature)

_____

Date