Dr. Majid Mirbahaeddin

Cowboys Dental, P.A.

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PAYMENT POLICY

To avoid any misunderstandings regarding insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees at the time of service. Our patients may use cash, check or credit card to pay their balances.

We **do not** render our services on the basis of what our paticents' insurance companics will or will not cover. We render our services based on our patients' oral health and the best treatment to maintain and/or restore our patients, oral health.

The portion that is charged to our patient is the **estimated** amount due from the patient based on what the insurance company has conveyed over the telephone to our office staff. However, if the insurance company dose not cover for all fees, the patient is responsible for any and all balances remaining.

We will file the primary insurance as a courtesy; however, the patient is responsible for all the fees incurred. **In addition to all other remedied patient shall pay Cowboys Dental P.A. expense and attorney fees incurred to collect monies owed to Cowboys Dental P.A. from patient under these terms.**

Patient Name: _____

Signature: _____

Today's Date: _____

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day-to-day healthcare operations of your practice.**

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the more current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out your treatment , payment, and healthcare operations, buy that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____,20_____.

Print Patient Name :_____

Relationship to Patient :_____

Signature: _____

WELCOME

1 About You

Name: _____ ( )
Last First Middle Initial

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: __/__/__ Age: ____ SS#: ___-___-_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: _____

City: _____ State: _____ Zip Code: _____

Hm#: (___)___-_____ Pager/Other#: (___)___-_____

Wk#: (___)___-_____ Ext. ____ DL#: _____

Employer: _____

Employer Address: _____ City: _____

How long there? _____ Occupation: _____

Where & when are the best times to call you: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous Dentis: _____

Last Dental Visit: _____

2 Spouse Information

His/Her Name: _____ ( )
Last First Middle Initial

Wk#: (___)___-_____ Ext.: ____ Birthdate: ____/____/____

SS#: ___-___-_____ DL#: _____ State: _____

Person Responsible for Account: _____ ( )
Last First Middle Initial

Wk#: (___)___-_____ Ext.: ____ DL#: _____

City: _____ State: _____ Zip Code: _____

Relation: _____ SS#: ___-___-_____

3 Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

_____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

☐ Yes ☐ No	Anemia/Radiation Treatment	☐ Yes ☐ No	Heart Surgery/Pacemaker
☐ Yes ☐ No	Artificial Bones/Joint	☐ Yes ☐ No	Hemophilia/Abnormal Bleeding
☐ Yes ☐ No	Artificial Valves	☐ Yes ☐ No	Hepatitis
☐ Yes ☐ No	Asthma, Arthritis	☐ Yes ☐ No	High/Low Blood Pressure
☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No	HIV+/AIDS
☐ Yes ☐ No	Cancer/Chemotherapy	☐ Yes ☐ No	Hospitalized for Any Reason
☐ Yes ☐ No	Congenital Heart Defect	☐ Yes ☐ No	Kidney Problems
☐ Yes ☐ No	Diabetes/Tuberculosis (TB)	☐ Yes ☐ No	Mitral Value Prolapse
☐ Yes ☐ No	Difficulty Breathing	☐ Yes ☐ No	Psychiatric Problems
☐ Yes ☐ No	Drug/Alcohol Abuse	☐ Yes ☐ No	Rheumatic/Scarlet Fever
☐ Yes ☐ No	Emphysema/Glaucoma	☐ Yes ☐ No	Severe/Frequent Headaches
☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No	Shingles
☐ Yes ☐ No	Fainting Spells	☐ Yes ☐ No	Sinus Problems
☐ Yes ☐ No	Fever Blisters/Herpes	☐ Yes ☐ No	Ulcers/Colitis
☐ Yes ☐ No	Heart Attack/Stroke	☐ Yes ☐ No	venereal Disease
☐ Yes ☐ No	Heart Murmur		

Please list any serious condition(s) that you ever had:

_____

_____

Are you allergic to any of the following?

☐ Yes ☐ No	Aspirin	☐ Yes ☐ No	Erythromycin	☐ Yes ☐ No	Latex
☐ Yes ☐ No	Codeine	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No	Any Metal/Plastic
☐ Yes ☐ No	Dental Anesthetics	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No	Other

Please list any other drugs that you are allergic to: _____

_____

4 Dental History

Why have you come to the dentist today? _____

_____

_____

Are you currently in pain?	☐ Yes	☐ No
Have you ever had a serious/difficult problem associated with any previous dental work?	☐ Yes	☐ No
Have you ever had gum treatment?	☐ Yes	☐ No
Are your teeth sensitive to hot or cold liquids/foods?	☐ Yes	☐ No
Are your teeth sensitive to sweet or sour liquids/foods?	☐ Yes	☐ No
Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Do you have frequent headaches?	☐ Yes	☐ No
Have you had any orthodontic work?	☐ Yes	☐ No
Have your ever had any prolonged bleeding following extractions?	☐ Yes	☐ No
Have you lost any teeth?	☐ Yes	☐ No

If yes, why? _____

_____

5 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: (____)____-_____ Ext. _____

Group # (Plan, Local or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

Policy Owner's Employer: _____

6 Emergency

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ (__)__
Last First Middle Initial

Relation: _____ Hm#: (____)____-_____

Wk#: (____)____-_____ Ext. ____

Pager/Other#: (____)____-_____

I understand that the information that I have given today is current and to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that insurance does not cover.

I understand that should this office need the assistance of a collection agency or attorney for collecting any unpaid balances, that I will be responsible for the collection agency's fees, attorney's fees, court costs and interest incurred.

_____ ____/____/____
Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.
Thank you for filling out this form completely.
It will enable us to help you more effectively.
If you have any questions at any time,
please ask us. We are happy to help.
Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the TDA and the ADA.