Welcome to Beautiful Smiles Dentistry!

It is a pleasure to have you here! We appreciate the confidence you place with us to provide you with optimal oral health! Please don't hesitate to ask for assistance with filling out this form!

Your Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Age:** _____ **Driver's License #:** _____ **SS#:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Email:** _____

Occupation: _____ **Employer:** _____

Work Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Spouse/Partner Name: _____ **Phone #:** _____ **Anniversary Date:** _____

Emergency Contact(other than spouse): _____ **Phone #:** _____

Primary Dental Insurance: _____ **Member ID #:** _____

Medical Insurance: _____ **Member ID #:** _____

Subscriber's Name (if other than you): _____ **Date of Birth:** _____ **SS #:** _____

Name of your Medical Doctor: _____ **Date of last visit to Medical Doctor:** _____

Preferred Pharmacy: _____ **Phone #:** _____

Name of Previous Dentist: _____ **Date of last visit to Dentist:** _____

Who may we thank for referring you? _____

Do you give us permission to send you text reminders about appointments or dental treatment? **YES** **NO**

Do you give us permission to send you email reminders about appointments or dental treatment? **YES** **NO**

Do you give us permission to leave voice messages on your home or cell phone about appointments or accounting? **YES** **NO**

Would you prefer to receive a postcard reminder for your upcoming appointments? **YES** **NO**

Dental History

Are you apprehensive about dental treatment?	YES	NO
Have you had problems with previous dental treatment?	YES	NO
Do you gag easily?	YES	NO
Do you wear dentures?	YES	NO
Does food catch between your teeth?	YES	NO
Do you have difficulty in chewing your food?	YES	NO
Do you chew on only one side of your mouth?	YES	NO
Do you avoid brushing any part of your mouth due to pain?	YES	NO
Have you ever noticed slow-healing sores in your mouth?	YES	NO
Do your gums bleed easily?	YES	NO
Do your gums bleed when you floss?	YES	NO
Do your gums feel swollen or tender?	YES	NO
Does your jaw get stuck so that you cannot open freely?	YES	NO
Does your jaw ever feel tired?	YES	NO
Does it hurt when you chew or open wide to take a bite?	YES	NO
Do you have any jaw symptoms or headaches when you wake up?	YES	NO
Do you take medications for pain or discomfort?	YES	NO
Are you unable to open your mouth as far as you want?	YES	NO
Are you aware of an uncomfortable bite?	YES	NO
Have you ever had orthodontic treatment?	YES	NO

Are your teeth sensitive?	YES	NO
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	YES	NO
Cold foods or liquids?	YES	NO
Sours?	YES	NO
Sweets?	YES	NO
Are you dissatisfied with the appearance of your teeth?	YES	NO
Do you clench or grind your teeth frequently?	YES	NO
Do you prefer to save your teeth?	YES	NO
Do you want complete dental care?	YES	NO
Are you aware of any snoring, sleep apnea or breathing issues?	YES	NO
Have you had trauma to the jaw?	YES	NO
Are you a habitual gum chewer or nail biter?	YES	NO

How often do you brush? _____

How often do you floss? _____

Do you use an electric toothbrush or waterflosser? If so, which brand(s):

_____

Medical History

***** Do you need Antibiotic Premedication before your appointment:**	YES	NO
Heart Problems:		
Chest Pain Shortness of breath:	YES	NO
Blood pressure Problem:	YES	NO
Heart murmur:	YES	NO
Heart valve problem:	YES	NO
Rheumatic fever Pacemaker:	YES	NO
Artificial heart valve:	YES	NO
Blood Problems:		
Bruise easily:	YES	NO
Abnormal bleeding:	YES	NO
Anemia or any blood disease:	YES	NO
History of blood transfusion:	YES	NO
Allergy Problems:		
Hay Fever:	YES	NO
Sinus Problems:	YES	NO
Skin Rashes:	YES	NO
Asthma:	YES	NO
Intestinal Problems:		
Ulcers:	YES	NO
Weight gain or loss:	YES	NO
Special diet:	YES	NO
Constipation/Diarrhea:	YES	NO
Kidney or bladder problems:	YES	NO
Arthritis:	YES	NO
Back or Neck Pain:	YES	NO
Joint Replacement:	YES	NO
Fainting spells, Seizures or Epilepsy:	YES	NO
Stroke(s):	YES	NO
Frequent Severe Headaches or Migraines:	YES	NO
Thyroid Problems:	YES	NO
Persistent Cough or Swollen Glands:	YES	NO
Cancer/Tumor:	YES	NO
If yes, what areas: _____		
Diabetes:	YES	NO
Urinate more than 6 times per day:	YES	NO
Thirsty or dry mouth:	YES	NO

Tuberculosis or other Respiratory Disease:	YES	NO
Do you drink alcohol: **YES** **NO** How much per day? _____		
Do you smoke: **YES** **NO** How much per day? _____		
Hepatitis, Jaundice or liver trouble:	YES	NO
Herpes or other STD:	YES	NO
HIV+ or AIDS:	YES	NO
Glaucoma:	YES	NO
History of head injury:	YES	NO
History of alcohol or drug abuse:	YES	NO
Any other condition or problem not listed: _____		
Allergies to any of the following?	YES	NO
Local Anesthetics (Epinephrine):	YES	NO
Penicillin or other antibiotics:	YES	NO
Sulfa drugs:	YES	NO
Sedatives:	YES	NO
Aspirin, Tylenol or Ibuprofen:	YES	NO
Codeine or other Narcotics:	YES	NO
Reaction to metals:	YES	NO
Latex:	YES	NO

Other allergies not listed: _____

Current medications and supplements: _____

Women:

Are you taking contraceptives or hormones?	YES	NO
Are you pregnant?	YES	NO
If yes, expected delivery date: _____		
Are you nursing?	YES	NO
Have you reached menopause?	YES	NO
If so, do you have any symptoms?	YES	NO

I attest that the above information is true and accurate to the best of my knowledge:

Patient Signature _____

Beautiful Smiles Dentistry

Getting to know you!

Patient Name_____ Date_____

"Our promise is to provide you the opportunity for a dental experience that meets or exceeds your expectations in a caring, comfortable, and professional atmosphere. We will provide you preventive care to enhance your smile, improve and maintain your dental function, and help you to prevent future dental problems."

To help serve your dental needs best, we would like to know more about you. Please take a moment to complete the following questions.

What do you expect from your visit with us today?

_____

_____

What is most important to you about you dental health?

_____

_____

In your opinion, what is the present condition of your mouth?

_____

What would you like your teeth to be like in 10 or 20 years?

_____

If you could "enhance" anything about your smile what would it be?

_____

Are there foods you enjoy but cannot eat due to discomfort with your teeth?

_____

Are you aware that there are medical conditions related to dental disease?

_____

What do you know about periodontal disease?

_____

What has been your overall experience in other dental offices?

_____

Has "fear" or "cost" ever prevented you from getting the dental treatment you need or want? Y__N__ Please explain:_____

What "quality" of dentistry do you want us to focus on at this time? Please circle:
A)Patch it B) Only what is covered by insurance C) Ideal/ Best

Should you be in need of treatment at what point do you plan to "get started"? Please circle:
A) When it hurts B) When it breaks C) When it is recommended in order to prevent further deterioration

Please feel free to let us know more about how we can help make this your best dental experience.

_____

_____

Beautiful Smiles Dentistry
151 N. Sunrise Ave Suite #1301
Roseville, CA 95661
(916)780-1955

Appointment Reservation Agreement

We provide our patients with scheduled appointment times. Please help us serve you and our other patients better by keeping scheduled appointments. Appointments that are missed or changed at the last minute are then unavailable to patients who need them. Therefore, a non-refundable fee of **$50.00** will be charged to your account. This fee cannot be billed to your insurance and therefore is your responsibility.

Our patients' time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. You can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

***Repeated cancelations or missed appointments will result in loss of future appointment privileges.**

***Patients who arrive 15 minutes late for their appointment may need to be rescheduled.**

***Appointments not confirmed via text, email or phone by 8am the day before your appointment date may result in the cancelation of your appointment.**

We would like to take this opportunity to welcome you to our office and assure that we will do our utmost to provide you the best care possible.

I have read and understand the above office policy. I have been provided with the answers to any questions I have at this time.

Patient Signature _____ Date: _____
(Patient or guardian if minor)

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Financial Policy and Insurance Benefits

(Please initial after each paragraph)

I am responsible for providing Beautiful Smiles Dentistry with insurance information that is correct and current. I consent to release any information necessary to an insurance company or 3rd party payer for purposes of payment. I authorize payment of insurance or 3rd party payer to Beautiful Smiles Dentistry for services rendered. _____

I undertake a personal obligation and responsibility for my account. I am responsible for knowing my insurance benefits._____

I understand that the benefit information collected over the telephone from my insurance company is not a guarantee of payment. _____

I understand that my portion will be collected at the time of service and is only an estimate. I understand that the actual amount of funds reimbursed to Beautiful Smiles Dentistry by my insurance company may be less or more than the original estimate._____

I understand that the amount not covered by my insurance company is my responsibility and is due in full at the time I receive my statement. _____

I understand that there is the option of a financial payment plan, based on approved credit, with *CareCredit* or *Lending Club* offered to me through Beautiful Smiles Dentistry. _____

Patients without insurance are requested to pay for services as rendered._____

I have read and understood the above office policy. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

Signature of Patient _____ Date _____
(Patient or guardian if minor)

Beautiful Smiles Dentistry
151 North Sunrise Ave., Suite #1301
Roseville, CA 95661
916.780.1955

IBTISAM RASHID, D.D.S
HANA RASHID, D.D.S.

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability act of 1996 ("HIPPA") requires that, effective April 14, 2003 we provide you with a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. We ask that you review it carefully, as the privacy of your health information is important to us. We are required to ask you to sign a one-time acknowledgement that you received this summary.

Dr. Rashids practice revises these policies and procedures as necessary and appropriate to remain in compliance with HIPAA and state law. Changes in law and changes in our procedures can lead to a revision of these written policies and procedures. Staff must comply with the current policies and procedures.

Uses of Protected Health Information

We are permitted to use your PHI for treatment purposes, payments and healthcare operations:

TREATMENT- We may use or disclose your health information to a physician, or other healthcare provider providing treatment to you.

PAYMENTS - We may use or disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS - We may use or disclose your health information to conduct our business and evaluate the quality and efficiency of our processes. We have put into effect safeguards to protect the privacy of your health information. However, there may be incidental disclosure of limited information, such as, overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of practice. HIPPA recognizes that such disclosures maybe extremely difficult to avoid entirely, and considers them permissible.

YOUR AUTHORIZATION - You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice**.** We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

UNSECURED EMAIL- We will not send you unsecured emails pertaining to your health information without your prior authorization.

CHANGE OF OWNERSHIP- If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

REQUIRED BY LAW- We may use or disclose your health information when we are required to do so by law.

APPOINTMENT REMINDERS- We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Patient Rights

ACCESS -You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

DISCLOSURE ACCOUNTING -You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

RESTRICTION -You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

ALTERNATIVE COMMUNICATION - You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

~AUTHORIZATION TO RELEASE YOUR INFORMATION~

I, (patient's or guardian's name)_____ authorize the following

individual(s)____BEAUTIFUL SMILES DENTISTRY___to use or get copies of my dental/health records.

Patients Signature_____ **Date**___/___/_____

I, _____ have received a copy of Dr.Rashid's Privacy Practices.

{Signature} _____ {Date}_____

FOR OFFICE USE ONLY

Could not obtain acknowledgement for the following reasons:_____

_____