PATIENT HISTORY

HOW WOULD YOU LIKE TO BE REFERRED TO (Nickname): _____ DATE _____

NAME: Ms Miss Mr Atty Mrs Dr _____
Last First M.I.

ADDRESS: _____
P.O. Box Street City State Zip + 4

DATE OF BIRTH: _____ SOC. SEC.#: _____ - _____ - _____

HOME PHONE: _____ FAX: _____

PHARMACY TELEPHONE NO. _____

BEEPER: _____ CELLULAR: _____

❑ MALE ❑ FEMALE
❑ Single ❑ Married
❑ Widowed ❑ Divorced
❑ Separated

EMPLOYER: _____ ADDRESS: _____

OCCUPATION: _____ BUSINESS PHONE: _____

PAYMENT BY: ❑ Cash ❑ Check ❑ Credit Card

ARE YOU INTERESTED IN FINANCING? ❑ Yes ❑ No

PERSON RESPONSIBLE FOR THE ACCT: (MUST SIGN AUTHORIZATION ON BACK)

_____

DENTAL INSURANCE CARRIER: _____

MEMBERSHIP #: _____

SOC. SEC.#: _____ - _____ - _____ D.O.B. _____

MEDICAL INSURANCE CARRIER: _____

MEMBERSHIP #: _____

SOC. SEC.#: _____ - _____ - _____ D.O.B. _____

SECONDARY INSURANCE CARRIER: _____

REFERED TO OFFICE BY: _____

SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

NEAREST RELATIVE: _____
(NOT LIVING WITH YOU)

ADDRESS: _____

PHONE: _____

LAST DENTAL CLEANING: _____

LAST DENTAL TREATMENT: _____

REASON FOR LEAVING PREVIOUS DENTIST: _____

_____

NAME OF PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

DATE OF LAST VISIT: _____

REASON FOR VISIT: _____

DESCRIBE GENERAL HEALTH: ❑ Good ❑ Fair ❑ Poor

PLEASE CIRCLE **Y** or **N** IF YOU HAVE OR EVER HAD ANY OF THE FOLLOWING:

Heart Murmur	Y N	Stroke	Y N	Prosthetic Valves or prothesis	Y N
Rheumatic Fever	Y N	Hepatitis A	Y N	Pacemaker	Y N
Scarlet Fever	Y N	Hepatitis B	Y N	Hips or Joints	Y N
Premedication before dental visits	Y N	Hepatitis C	Y N	Metal Pins / Plates	Y N
Difficulty Breathing	Y N	AIDS - HIV +	Y N	(Not including dentures or partial dentures)	
Difficulty Swallowing	Y N	Venereal Disease	Y N	Orthodontics	Y N
Heart Disease	Y N	Tuberculosis	Y N		
High Blood Pressure	Y N	Diabetes	Y N	**MEDICATIONS:**	
Low Blood Pressure	Y N	Ulcer	Y N		
Seizures	Y N	Asthma	Y N		
Epilepsy	Y N	Arthritis	Y N	Birth Control or Hormone	Y N
Anemia	Y N	Pregnant at Present	Y N	Others:	
Chicken Pox	Y N	Kidney Disorders	Y N	Other Significant Past or Present Conditions	
Measles	Y N	Emotional Disease	Y N	including Surgery/Hospitalization:	
Mumps	Y N	Bleeding Problems	Y N		
History of Cancer: (Family)	Y N	Difficulty Healing	Y N		
If yes, describe:		Allergies to Medications	Y N		
				Do you use Tobacco?	Y N
❑ Radiation				Do you use Alcohol?	Y N
❑ Chemotherapy		Significant Weight Loss or Gain	Y N	Do you use Caffeine products?	Y N

DENTAL PROBLEMS: ❑ Bleeding Gums ❑ Broken Filling ❑ Broken Tooth ❑ Pain
❑ TMJ ❑ Cosmetic Screening ❑ Sensitivity ❑ New Patient Exam

Blood Pressure _____

_____ Height _____ Weight

Are you happy with the appearance of your teeth? Y N

Are you interested in preventing snoring? Y N

Do you play sports? Y N

_____
Signature of Patient

_____
Signature of Doctor

<< OVER >>

ARK Dental LLC
Administrative Offices at 41 Locust Street
Northampton, Massachusetts 01060

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient#: _____ Social Security#: _____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations and of the uses and disclosures we may make of your protected health information, and all of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ali Kasemkhani, DMD, Compliance Officer
Telephone: (413) 586-0157
Email: arkdentalllc@gmail.com
Address: ARK Dental LLC, 41 Locust Street, Northampton, MA 01060

Right to Revoke: You will have the right to revoke this consent at any time by giving us notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my Consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Present completed Consent to the office

AUTHORIZATION

Name of Patient: _____

I, the undersigned, hereby authorize payment directly to the Doctors, of dental benefits, if any, otherwise payable to me under the terms of my dental insurance policy.

I fully understand that I am primarily and financially responsible for fees incurred by the above patient; I further understand that payment to said Doctor is not contingent on any settlement, judgment or verdict by which the above patient may eventually recover said medical/surgical fees.

I hereby agree that I, the undersigned, shall be liable for any attorney's and court fees and/or collection costs incurred by the Doctor in the event that such dental bills are placed with an attorney or other third party. This fee will be 40% of unpaid balance added to account.
1.5% finance charge per month on balance over 60 days. Annual percentage rate 15%

I hereby authorize medical/dental surgical treatment, care and/or services by the Doctor to the above named patient.

I hereby authorize the Doctor to release any information acquired in the course of examination or treatment, with my knowledge of consent.

I hereby authorize any physician, health care practitioner, hospital or medical care facility to provide all information on the above patient's medical history to the Doctor.

I hereby authorize the doctors to take photographs for promotional or esthetic reasons.

I hereby authorize the doctors to take photographs for educational and professional purposes.

I hereby authorize photocopies of this form to be valid as the original.

Parents and/or guardian are requested to inform the office if they are not going to be present for their child's appointment.

I authorize the doctors to take necessary radiographs and administer in office fluoride treatments to my children.

Date: _____ Signature:_____
Patient, Parent, Guardian

If patient is a minor, who has legal and financial responsibility?

Name: _____

Address: _____

City: _____ ST: _____ ZIP: _____

Date: _____ Signature: _____

ARK DENTAL
FINANCIAL POLICY LETTER

Dear _____,

Our mission at ARK Dental, LLC is to deliver the finest, most cost effective health care treatment available. Following your diagnosis, the Doctor will advise you of our plan for treatment. We will then discuss with you the cost of today's treatment as well as any future treatment. Payment for today's visit and any future visits is due at the time of treatment. We are sensitive to the fact that some patients may not be able to pay cash for their treatment; therefore, we offer several alternative payment programs for your convenience.

INSURANCE
We will gladly process your insurance claim; estimate your deductible and the portion not covered by your insurance (co-payments). The estimated amount not covered by insurance is due at the time of your treatment and may be paid by one of the options below. Our estimates are subject to final approval by your insurance company; therefore, the amount due in our office is subject to change.

INITIAL PAYMENTS (EXTENSIVE TREATMENT)
Our office requires a deposit of equal to one-half (50%) of the planned treatment cost in order to schedule the appointment to start treatment. Payment is due in full once treatment is initiated. We ask that a 24-hour notice be given if you are unable to keep a scheduled appointment. If we DO NOT receive a 24-hour notice, a fifty ($50) dollar deposit will be necessary to secure any future dental appointments.

PAYMENT OPTIONS
1. Cash or check (includes money orders)
2. Visa/Mastercard/Discover
3. Care Credit – Separate line of credit – does not affect other credit card balances, processing takes only minutes and allows for various financing options, for more information inquire at front desk.
4. Pulse Care – separate line of credit – for more information inquire at front desk.
5. Dental Fee Plan – also a separate line of credit – with a monthly payment plan available.

We would be very happy to work with you to plan the most appropriate arrangements for your budget. Financing your treatment will allow you to begin your treatment immediately and spread the cost over a period of time appropriate for you.

_____ _____ _____
*Patient/Parent/Guardian Signature Financial Coordinator Date

I understand the financial arrangement, and I have had the opportunity to ask questions. I have been informed of all financial arrangements available to me from this office.
I have additional questions: _____
I have no additional questions: _____

_____ _____ _____
*Patient/Parent/Guardian Signature Financial Coordinator Date
*If patient is a minor, a parent or guardian must sign