Rima Shahhal DDS & Sami Shahhal DDS

740 Nordahl Rd. , Ste 121 • San Marcos, CA 92069 (760)746-7008

Welcome to Nordahl Dental

Chart#: FOR OFFICE USE ONLY

Patient Name: * Last * First MI

Preferred Name

Title: **Gender:** * Mr/Ms/Mrs/etc ○ Male ○ Female

Family Status: * ○ Married ○ Single ○ Child ○ Other

Birth Date: *

SS#:

Prev. Visit:

Email Address:

Best time to call:

Phone: * Home Mobile Work Ext

Fax Other

Address: * Address 1

Address 2

* City * State * Zip Code

Emergency Contact: *

In an emergency, who should be notified? Please enter name, phone number and relationship below: *

Whom can we thank for referring you to our office? *

- ☐ Insurance Provider Directory
- ☐ Yelp
- ☐ Google
- ☐ Office Website
- ☐ Other Dental Office
- ☐ Facebook
- ☐ Friend/Family
- ☐ Other

Employment

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____

Phone: _____

Employer Address: _____
Address 1

_____
Address 2

_____
City

_____ _____
State Zip Code

Insurance Subscriber and/or Parent/Guardian Information

This page ONLY needs to be completed if the insurance subscriber is OTHER than the patient AND/OR you are the parent/guardian of the patient

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ _____
Last First MI

_____
Preferred Name

Title: _____ **Gender:** _____ ◯ Male ◯ Female
Mr/Ms/Mrs/etc

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

SS#: _____ **DL#:** _____

Email Address: _____

Best time to call: _____

Phone: _____ _____ _____ _____
Home Mobile Work Ext

_____ _____
Fax Other

Address: _____
Address 1

_____
Address 2

_____ _____ _____
City State Zip Code

Primary Dental Insurance

Name of Insured:

Last

First MI

Insured's Birth Date:

ID #: **Group #:**

Insured's Address:

Address 1

Address 2

City

State Zip Code

Insured's Employer Name:

Employer Address:

Address 1

Address 2

City

State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

Address 1

Address 2

City

State Zip Code

Insurance Authorization

☐ * **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic 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.

Do you have secondary dental insurance? * ◯ Yes ◯ No

Dental Information

What is your immediate concern about your dental health? *

How would you rate the condition of your mouth? *

○ Excellent ○ Good ○ Fair ○ Poor

Previous Dentist Name and Phone Number *

Approximate date of most recent dental exam and/or dental x-rays *

I routinely see a dentist every *

○ 3 mos ○ 4 mos ○ 6 mos ○ 12 mos ○ Not routinely

Is there anything about the appearance of your smile that you would like to change?

Check all that apply

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/Have braces or orthodontic treatment
- ☐ Experiences dry mouth
- ☐ Sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Whitened or bleached your teeth
- ☐ Experienced popping and/or clicking of your jaw joint
- ☐ Difficulty chewing
- ☐ Clenching or grinding of teeth
- ☐ Currently or previously wore a bite appliance
- ☐ Wears removable partial/denture
- ☐ Gums bleed when brushing or flossing
- ☐ Diagnosed and/or treated for gum disease
- ☐ Bone loss around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ Snores or wakes up frequently during the night

If any of the checked boxes need further explanation, please describe:

Financial Policy

Our mission is to deliver the finest, most cost-effective health care treatment available today. Following diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the investment in today's and future treatment.

Payment is due at the time services rendered. For your convenience we accept cash, personal check, Visa, MastercCard, & Discover. We also offer convenient payment options through CareCredit.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimsted co-payment amount will be due at the time of tteatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer.

As a courtesy we will be glad to file your claim for you, provided we have complete and accurate insurance information. You will be expected to pay for services rendered if the office is unable to verify your insurance information prior to treatment. If payment for services already rendered has not been received within 45 days, either by you or your insurance company, the remaining balance for tteatment is considered due and collectible. Collection agency fees (35% standard collection/50% legal collection) will be added to your existing balance if the services are utilized. Your cooperation with this policy will assure equitable tteatment of insured and non-insured patients.

We reserve the right to charge and collect fees for broken appointments. Appointments are reserved exclusively for you. We consider an appointment confirmed once the appointment is scheduled. A minimum charge of $50.00 per hour may be posted to your account if an appointment is canceled without a 48 hour advance notice. Any accounts overdue for patient payment in excess of 45 days are subject to an interest fee of 18% per commencing tteatment.

☐ * **By checking this box, I authorize payment of the dental benefits otherwise payable to me, directly to Rima C. Shahhal, D.D.S.**

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgment

☐ * **I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). 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.)
Obtain payment from third party payers (e.g. my insurance company)
The day to day healthcare operations of the practice.

I also have been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses af disclosures of my protected health information and my rights under HIPPA. (Copies available in office) I understand I reserve the right to change terms of this notice from time to time to obtain the most current copy of this notice. I understand I have the right to request restrictions on how my protected health information is used and restricted to carry out treatment, payment, and health care operations; but that you are not required to agree to these requested restrictions. However, if you agree, you are then bound to comply with these restrictions.
I understand that I may revoke this consent, in writing at any time. However, any use or disclosure prior to the date I revoke this consent is not affected.

By checking this box, I acknowledge that I have read, understand and consent to the above HIPPA Policy and statements.

I authorize this dental practice to release any financial or dental information to the following person(s) listed below: _____

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Photography

☐ * **I authorize Dr. Sami I. Shahhal & Dr. Rima Shahhal to take photographs of my teeth. I understand that the photographs and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrtations, professional publications, website and media. I understand that if the photographs, slides, and/or videos re used in any publiclication or as a part of a demonstration, my name and other identifying information will be kept confidential. NO FULL FACE PPHOTOS WILL BE USED WITHOUT YOUR EXPRESSED WRITTEN CONSENT. I do not expect compensation, financial or otherwise, for the use of these photographs. By checking this box, I acknowledge and agree to abide by such policies.**

Name of patient, parent or guardian completing these forms: *

Relationship to patient: *

○ Self ○ Parent ○ Guardian ○ Spouse ○ Other