



Dental Solutions

Riad Almasri, D.D.S.

3102 Oak Lawn Ave, Suite 204
 Dallas, TX 75219
 214-521-5900

PATIENT REGISTRATION

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Responsible Party (if someone other than the patient) _____

Address _____ City/State/Zip _____

Whom may we thank for referring you? _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed Partnered Other

Birth Date: _____ Age: _____ Soc. Sec: _____ - _____ - _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail Yes No

Emergency Contact: _____ Phone: _____ Relationship: _____

Patient Employed By: _____ Spouse/Partner Employed By: _____

Insurance Information

Insured Name: _____ Relationship to Patient: Self Spouse/Partner Parent

If insured is other than patient: Insured Birthdate: _____ Insured Social Security Number or ID #: _____

Insurance Carrier: _____ Group Number: _____

Carrier Address: _____ City, State, Zip _____

Carrier Phone: _____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my health care, advice and treatment to another dentist.

I understand that Dental Solutions is **not** a contracted provider with my insurance carrier. My dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of **all** accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

 Patient Signature

 Date



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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

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

- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| Alzheimer's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A | <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily Winded | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles / Herpes Zoster | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint | <input type="checkbox"/> Yes <input type="checkbox"/> No | Excessive Thirst | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells/Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Limbs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis (T.B.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in Jaw Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pace Maker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Trouble/Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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 _____ DATE _____

SIGNATURE OF DENTIST _____ DATE _____

MEDICAL HISTORY CONTINUED

Are you taking any medications, pills, or drugs? Yes No
If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No (If so, when? _____)

Do you use tobacco? Yes No
If so, do you Smoke? Yes No How Much? _____

Do you Chew Tobacco? Yes No How Much? _____

Do you use controlled substances? Yes No

Do you consume alcohol? Yes No
If so, how much per day / week / month? _____

Have you every had psychiatric treatment? If so, please explain _____

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

If yes, please explain: _____

Would you like to speak to the Doctor privately about any problems or conditions? Yes No

Physicians Name _____ **Phone** _____

Please list below, any medications you are currently taking and dosing: (Please use the back of this page if necessary)

Medication _____ Dosing _____ Instructions _____

Medication _____ Dosing _____ Instructions _____

Medication _____ Dosing _____ Instructions _____

Medication _____ Dosing _____ Instructions _____

Medication _____ Dosing _____ Instructions _____

Medication _____ Dosing _____ Instructions _____

Medication _____ Dosing _____ Instructions _____

Medication _____ Dosing _____ Instructions _____



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DENTAL HISTORY

Previous Dentist Name _____ Phone _____

Date of last exam _____ What was done at that visit? _____

Yes No Have you ever been told you need to pre-medicate for a dental visit? Please list medication _____

Yes No Have any of your teeth been lost or removed? Please indicate what teeth and date of loss _____

Yes No Have the teeth been replaced? _____

Yes No Are you happy with the replacement? _____

Yes No Have you ever had gum treatment, gum surgery, or deep cleaning? When? _____

Yes No Have you ever had orthodontic work? When? _____

Yes No Do you currently wear retainers? (upper or lower / both?) _____

Yes No Do you currently wear a TMJ or clenching/grinding appliance? (upper or lower?) _____

Yes No Have you experienced pain or soreness in the muscles of your face or around your ear? _____

Yes No Does your jaw click or pop? _____

Yes No Do you have frequent headaches, neck aches, or sore shoulders? _____

Yes No Does food get caught in your teeth? Where? _____

Yes No Are your teeth sensitive to hot, cold, sweets, or pressure? _____

Yes No Are you happy with the appearance of your teeth? _____

Yes No Do you feel your breath is offensive at times? _____

Yes No Is there anything additional you would like us to know about your previous dental treatment? _____

How often do you brush your teeth? _____ Floss? _____

Purpose of today's visit _____

Describe any dental problems or needs you are aware of _____

Describe any questions you may have regarding improving the appearance of your teeth _____



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NOTICE OF PRIVACY PRACTICES – (HIPPA)
How Your Health Information May Be Used

To Provide Treatment

We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff. In addition, we may share your health information with physicians, referring, dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as a part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you and your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventative and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders, or email (unless you notify us in writing that our do not wish to receive these reminders.)

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes including under certain circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends, and Caregivers

We may share your health information with those you notify us in writing will be helping you with your home hygiene, treatment, medications or payment.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization at any time in writing.

Signature of Patient

Date



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FINANCIAL POLICY

- PAYMENT:** Payment is due at the time of service. We do not accept post-dated checks. We do accept cash, personal Checks (current date), major credit cards, debit cards, and third party financing through Care Credit or Chase.
- INSURANCE:** As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable Effort to collect covered amounts from your insurance company. Deductibles, co-payments, and non-covered Amounts are due at the time services are rendered. (Delta Dental and Blue Cross Blue Shield patients will need to pay in full and be reimbursed by their insurance company due to Delta and BCBS requirements.) All estimates quoted are based upon information provided to us by your insurance company and are estimates only and are not a guarantee of payment. The patient is ultimately responsible for all charges incurred. Insurance companies are required by law to pay claims within 30 days. After 60 days, any unpaid claims will become the sole responsibility of the patient. At that time outstanding amounts to insurance will be required to be paid in full by the patient. Please be advised, we are NOT participating providers with ANY insurance carriers. Our first and only priority is our patients and the quality of care, not the negotiation of benefits between the insurance company and your employer.
- RETURNED CHECKS:** All returned checks are subject to a \$30.00 returned check fee. After a check has been returned, all future payments will be on a cash or credit card basis.
- DELINQUENT ACCOUNTS:** Accounts over 90 days past due will be handled by our collection service. The patient agrees to pay ALL collection costs in addition to fees for service.
- CANCELLATIONS:** It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only and are scheduled with the dentist or hygienist one patient at a time. This allows us to focus our efforts on caring for and treating our patients to the best of our abilities. Thus, we require a minimum of 24 hours notice for cancellations and reschedules. This is necessary to allow us adequate time to notify patients who are on a waiting list for the first available appointment. Lack of adequate notice inhibits us from offering an exceptional standard of care to our other patients. A fee of \$100 per hour scheduled may be charged for failed appointments, inadequate notice of cancellation, or rescheduling of an appointment with less than 24 hours notice. We appreciate your cooperation and respect of our efforts.

I have read the above and I understand and agree to these terms regarding my treatment by Kenneth E. Riha, D.D.S.

Patient Signature

Date