AMA DENTAL

A. Michael Alsouss D.D.S.

Family, Cosmetic & Implant Dentistry

"Where patient experience and comfort come first"

PATIENT INFORMATION

WE ARE PLEASED TO WELCOME YOU TO OUR OFFICE. PLEASE TAKE A FEW MINUTES TO FILL OUT THIS REGISTRATION FORM. IF YOU HAVE ANY QUESTIONS WE'LL BE HAPPY TO HELP YOU.

PERSONAL

FIRST NAME:_____ LAST NAME:_____ DOB: _____-_____-_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____-_____ CELL PHONE: (_____)_____-_____

EMAIL: _____@_____._____

SS#_____-_____-_____ GENDER: MALE_____ FEMALE_____ MARRIED: YES_____ NO_____

EMPLOYER: _____ WORK PHONE: (_____)_____-_____

PREFERRED METHOND OF CONTACT (*CIRCLE ONE*): HOME WORK CELL EMAIL

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

(IF SOMEONE REFERRED YOU MAKE SURE TO WRITE THEIR NAME SO WE CAN THANK THEM!)

INSURANCE

INSURANCE NAME: _____ PHONE: (_____)_____-_____

SUBSCRIBER NAME: _____ DOB: _____-_____-_____

SUBSCRIBER (CIRCLE ONE): SELF SPOUSE CHILD

GROUP NUMBER: _____ SUBSCRIBER ID #: _____

STUDENT STATUS (IF OVER 19) (*CIRCLE ONE*) : NON-STUDENT FULL-TIME PART-TIME

SECONDARY INSURANCE

INSURANCE NAME: _____ PHONE:(_____)_____-_____

SUBSCRIBER NAME: _____ DOB: _____-_____-_____

SUBSCRIBER (CIRCLE ONE): SELF SPOUSE CHILD

GROUP NUMBER: _____ SUBSCRIBER ID #: _____

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MEDICAL HISTORY

LAST NAME:_____ FIRST NAME: _____

NAME OF MEDICAL DOCTOR: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE NUMBER: (_____)_____-_____

LIST OF MEDICATIONS OR DRUGS YOU ARE TAKING:

LIST OF MEDICATIONS YOU ARE ALLERGIC TO:

ARE YOU ALLERGIC TO LATEX? _____

DO YOU NEED TO TAKE A PREMEDICATION BEFORE DENTAL PROCEDURES? _____

CIRCLE IF YOU HAVE ANY OF THE FOLLOWING:

ASTHMA	PSYCHIATRIC PROBLEMS	HIP/KNEE REPLACEMENT
HEART ATTACK/STROKE	ALCOHOL/DRUG ABUSE	BACK PROBLEMS
MITRAL VALVE PROLAPSE	TUBERCULOSIS (TB)	CHEMOTHERAPY
ARTIFICIAL VALVES	JAW PROBLEMS (TMJ)	DIABETES
CONGENITAL HEART DEFECT	SHINGLES	HIGH BLOOD PRESSURE
CHEST PAINS	HEPATITIS	LOW BLOOD PRESSURE
NERVOUSNESS	ON BLOOD THINNERS	THYROID PROBLEMS
HIV/AIDS		

TOBACCO USE? IF SO, WHAT KIND AND HOW MUCH?_____

UNUSUAL REACTION TO DENTAL ANESTHETICS? IF SO, WHAT TYPE? _____

REASON FOR TODAY'S VISIT?_____ ARE YOU IN PAIN?_____

HAVE THERE BEEN ANY DENTAL X-RAYS TAKEN IN THE PAST YEAR? _____

NAME OF FORMER DENTIST? _____

DATE OF LAST DENTAL CLEANING AND EXAM? _____

Patient Signature: _____ Date: _____

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FINANCIAL AGREEMENT

In an effort to reduce costs, increase efficiency and maintain a higher level of professional care, we have created a financial policy that both patients and office personnel must adhere to.

Our office FINANCIAL POLICY is as follows:

1. Although our office will assist you in processing your insurance claims, please understand it is your responsibility to satisfy any account balance in FULL for all services rendered; an insurance ESTIMATE is just that; an estimate; we can also PRE-DETERMINE treatment therefore knowing a better estimate of further treatment.

2. We accept most PPO insurance plans, and will gladly process the claim for you; however any ESTIMATED DEDUCTIBLE, CO-PAYMENTS, AND SECONDARY COVERAGE will be DUE IN FULL at time of visit. Reimbursement will be made if insurance over pays.

3. We accept payment by CASH, CHECK, VISA, MASTERCARD, DISCOVER, CARE CREDIT, AND FLEX CARDS.

Reimbursement will be made if any insurance payment is made.

Any questions regarding these financial policies, please do not hesitate to speak with our office personnel. We are here to help you in every way possible.

PRINTED NAME: _____ DATE: _____

SIGNATURE: _____

NOTICE OF PRIVACY POLICIES/HIPPA

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This notice describes how we protect your medical information and what rights you have regarding it. You will be able to have direct access and review this information at any time applicable. Please know that this practice has the right at any time to change our Notice of Privacy Policies.

PLEASE REVIEW THIS CAREFULLY

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that my information can and may be used for the following:

- Conduct, plan and direction of my dental treatment and follow-up among the healthcare providers who may be involved in my treatment either directly or indirectly. (Insurance companies, other healthcare providers, etc.)
- Conduct normal healthcare operations to run the practice on a daily basis.
- Obtain payments from myself or third parties.
- We may call, text, or email to remind you of scheduled appointments, treatment and upcoming promotions and referral offers going on in our office.
- Unless you give us specific instructions or tell us otherwise, we will email/text you an appointment reminder and/or leave you a reminder message on your home or cell phone.

ANY INFORMATION ABOUT APPOINTMENTS OR TREATMENT WILL NOT BE DISCUSSED WITH ANYONE BESIDES YOURSELF OR PARENTS OF UNDERAGE DEPENDENTS.

- I have thoroughly read and understand your Notice of Privacy Policies with a more complete description of the uses of my healthcare information.
- I understand that the use of my personal health information will only be used to the advantage of my treatment and care.
- I understand that this practice does have the right to change its notice of privacy practices rights from time to time if needed, and that I may contact this practice at any time to obtain a copy of my HIPPA forms, and or my health information.
- I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment , payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent at any time, except to the extent that you have taken action relying on this consent.

PRINTED NAME: _____ DATE: _____

SIGNATURE: _____

PATIENT AUTOMATIC CONFIRMATION SYSTEM

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A. Michael Alsouss D.D.S.
5500 Broadview Road
Parma, OH 44134
216-351-5500

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In an effort to improve communication with our patients, we have implemented an appointment reminder system. This allows us to deliver appointment reminders via email and/or text messages.

Should you feel that this way of appointment reminders will be beneficial for you; please let us know the most convenient way of contacting you for future appointments.

If you would like to OPT out of this service; please let us know your best way of contact.

Fill in one or both:

- Cell Phone: (_____)_____-_____
- Email: _____@_____._____
- Opt-Out: (phone calls only)

The text message and email procedure involves sending a C for confirmation not to message back; again this is an automated system; should you need to reschedule an appointment or let us know your running late; A CALL MUST BE MADE to the office.

PRINTED NAME: _____ DATE: _____

SIGNATURE: _____

MISSED APPOINTMENT POLICY

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In order to give all of our patients the best possible care, we request that you review our policy regarding missed appointments.

A missed appointment is classified as the following:

- Not showing up for your visit
- Not giving us at least 24 hours notice to reschedule

We make every effort to accommodate your scheduling needs, and in return, we ask that you keep your reserved appointment time, arrive on time, and notify us a minimum of twenty four hours in advance if you need to reschedule. When we receive advanced notice of a cancellation, we are able to then accommodate other patients who are in need of care.

We understand that emergencies may arise, and you may need to reschedule your appointment, however, there are consequences for cancellations or no show appointments within a twelve consecutive month period.

1. First missed/cancelled appointment without proper notice=Warning
2. Second missed/cancelled appointment=Final Warning
3. Third missed/cancelled appointment= $25.00 **non refundable** fee placed on account to be paid at your next visit.

- Each missed appointment after this is also accessed a $25.00 fee for each missed/cancelled appointment without proper notice

Let's work together to provide you with the best possible care you deserve!

Patient Name: _____ Date: _____

Patient Signature:_____

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