Daniel D Mashni DDS

Cosmetic Dentistry
Invisalign
Pediatric & General Dentistry
Whitening
Periodontics
Implants
Financing

Date:_____ How were you referred to our office?_____

Patient Information Sheet

Name:_____ Male/Female Date of Birth:_____ Age_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home #:_____ Cell #:_____ Work #:_____

Primary Phone #:_____

Social Security #:_____

Email Address:_____

Guardian Information/Spouse Information

Guardian/Spouse Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home #:_____ Cell #:_____ Work #:_____

Insurance Information

Insurance is billed as a courtesy to our patients. Patient copayment serves as estimate only. You will be responsible for all treatment fees not paid by your insurance company.

Please initial_____

Primary Subscriber Name:_____ Date of Birth:_____

ID #:_____ SS #:_____

Insurance company name:_____ Phone #:_____

Group Number:_____

Secondary Subscriber Name:_____ Date of Birth:_____

ID #:_____ SS #:_____

Insurance company name:_____ Phone #:_____

Group Number:_____

Patient/Guardian Signature:_____ **Date:**_____

Assistant_____ **Doctor**_____ **Hygienist**_____

Are your teeth sensitive to:

Heat?	Yes No
Cold?	Yes No
Sweets?	Yes No
Biting Pressure?	Yes No

Does food get caught between your teeth? Yes No

Do your gums bleed when brushing? Yes No

Do you have swelling? Yes No

Do you notice bad mouth odor? Yes No

Problems with your jaw: Yes No

Difficulty opening or closing? Yes No

Difficulty chewing? Yes No

Do you avoid any part of your mouth while brushing? Yes No

Have you had a reaction to a local anesthetic? Yes No

Are you dissatisfied with the appearance of your teeth? Yes No

Do you smoke? Yes No

Do you have missing teeth? Yes No

Do you want to lose any teeth? Yes No

Do you have any fears of having Dental Work? Yes No

If so, explain:_____

_____

Are you concerned about the finances required to return your teeth to excellent health? Yes No

Will you need a payment plan to cover your expenses? Yes No

Do you have frequent headaches? Yes No

Do you snore? Yes No

Have you been diagnosed with sleep apnea? Yes No

Do you have crowding or spacing? Yes No

Have you been diagnosed with HPV? Yes No

When was your last dental appointment?_____

_____

Do you have any general health problems? Yes No

If so, please specify:_____

_____

Have you had surgery? Yes No

If so, explain:_____

_____

Are you currently under a physician's care? Yes No

If so, explain:_____

_____

Any Medications? Yes No

If so, please list:_____

_____

To the best of your knowledge, do you or your family members have the following medical conditions?

Heart Ailment	Yes No	me / family
Diabetes	Yes No	me / family
Rheumatic Fever	Yes No	me / family
Epilepsy	Yes No	me / family
High Blood Pressure	Yes No	me / family
Respiratory Disease	Yes No	me / family
Hepatitis	Yes No	me / family
HIV Positive	Yes No	me / family
Prolonged Bleeding	Yes No	me / family

Allergy to any Medications? Yes No

If so, please list:_____

_____

Are you pregnant? Yes No

Patient/Guardian Signature:_____ **Date:**_____

Assistant_____ **Doctor**_____ **Hygienist**_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Daniel D Mashni D.D.S., P.L.L.C
"ALL SMILES"

PLEASE SIGN THE FORM BELOW UNDER THE HEADING "CONSENT" TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PART ONE: **Acknowledgement of Receipt of Privacy Notices**

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above named practice.

Signature:_____ **Date:**_____

If a personal representative signs this authorization on behalf or the individual please complete the following.

Personal Representative's Name:_____

Relationship to Individual: _____

FOR OFFICE USE ONLY:

PART TWO: Good faith effort to obtain acknowledgement of Receipt

Patient refused to sign:

Describe your good faith effort to obtain the individual's signature on the form: _____
_____

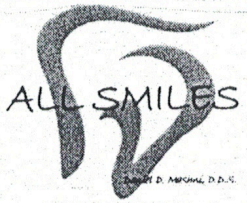
Describe the reason why the individual would not sign the form: _____
_____

PATIENT CONSENT

I attest that the above information is correct.

Patient Signature:_____Date:_____

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE



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www.smilesbydrmashni.com

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. However, due to many changes in insurance policies, it is no longer an easy task to interpret each individual's policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company prior to any office procedures. We charge what is reasonable and customary for our area. That being said, you are responsible for payment regardless of any insurance company's determination of "usual" and "customary" rates. Understand that not all services are covered by benefits in all contracts. That is to say that some insurance companies arbitrarily select certain services they will cover. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered. Ultimately, it is the patient's responsibility to know their individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit.

Payments for services are due at the time services are rendered unless our staff has approved payment arrangements. We accept cash, check, Discover, MasterCard or Visa, and also offer financing through credit companies.

We realize that temporary financial problems my affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Initial_____

I consent to treatment by **Daniel D Mashni D.D.S.** for myself and/or minor child. I have been provided the practice's statement regarding use and disclosure of my protected health information. I understand I may have a copy of this statement if I request it from the practice's privacy officer.

I authorize the release of any information necessary to process my claims and authorize payment to

Daniel D Mashni D.D.S.

Your signature below verifies that you have read and understand this statement, and that all of your questions have been answered.

Signature_____ Date_____

TO OUR PATIENTS

- I authorize Dr. Daniel Mashni to perform dental procedures on myself as needed, to take dental xrays to diagnose conditions that are needed for treatment.

- I understand that I am responsible for payment of services rendered and also responsible for paying and co-payment and deductible that my insurance does not cover

- I understand that payment is due at time that services are rendered

- I authorize my insurance company to pay by check made out to Daniel D Mashni DDS, PLLC. This is a direct assignment of my rights and benefits under this policy

- I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case

- I understand that I am subject to a $35 dollar cancellation fee if no notice is given within 24 hour period.

SIGNATURE: _____

DATE: _____