Reem Kidess, D.D.S., P.L.L.C.
7373 North Scottsdale Road Suite A-220
Scottsdale, AZ 85253

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Occupation:_____ Gender:_____ Family Status: _____ Birth Date:_____

Phone (Home):_____(Work): _____(Cell):_____

E-Mail: _____Preferred method of contact: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies
  - ☐ Penicillin
  - ☐ Codeine
  - ☐ Sulfa
  - ☐ Latex
  - ☐ Any other_____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
  - ☐ Coumadin
  - ☐ Heparin
  - ☐ Plavix
- ☐ Cancer
  - ☐ Radiation Therapy
  - ☐ Chemotherapy

When was your last cancer treatment_____

- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorder
- ☐ Osteoporosis
  - ☐ taking bisphosphonates
- ☐ Pacemaker
- ☐ Pregnancy
  Due Date_____
- ☐ Currently trying to get pregnant
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Do you need to Pre-med before any dental treatment?

OTHER:
- ☐ _____
- ☐ _____
- ☐ _____

- Please list all medications either prescription or OTC that you are currently taking:

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Reem Kidess, D.D.S., MAGD, P.L.L.C.
7373 N. Scottsdale Rd. Suite A-220, Scottsdale, AZ 85253
Tel: (480) 991-2290 www.PVsmiles.com

Our Appointment & Financial Policy:

Dear Patient,

Welcome to our office. We at Dr. Kidess's office are proud to be part of a team whose primary mission is to deliver the finest quality dental care and customer service available. In addition, we are also dedicated to making this top-quality care as cost-effective as possible. We will always inform you of what the fee for your treatment will be prior to initiation. To assist you with your healthcare investment, we provide the following payment options:

Payment is due at the time of treatment.
Please note that we do reserve the right to require pre-payment at the time of scheduling an appointment that may require blocking off a large segment of treatment time.

Payment options:

1. Cash or Check,
2. Major Credit Cards (Visa, Master Card, American Express, Discover)
3. CareCredit: Payment plan - offers no and low interest options. Instant approval available, allows you to start treatment immediately, and spread payments over time. (Subject to credit approval).

There will be a $25.00 charge for returned checks.

Dental Insurance – We directly participate with Delta Dental Premier. We do accept most other PPO or indemnity dental insurance plans. We will be glad to file your claims for you to maximize your reimbursement from your dental insurance**. Please note that any unpaid balance will be your responsibility.**

Your Appointment Time:

- We take great pride in trying to stay on schedule, in order to reduce any inconvenient waiting time for our patients. Therefore we ask you to also, please be on time for your appointment.
- **If you need to reschedule your appointment, a minimum of 48 hours notice is requested**.
- If you **cancel** an appointment **with less than 48 hours notice**, or do not show up for an appointment that constitutes a broken appointment, and there will be a minimum of a $100.00 fee charged per hour for that appointment. Also, **you will need to reserve future appointments with a credit card deposit.**

We would like to thank-you for trusting us with your dental care, and we promise to always treat you with the utmost care and respect.

Patient Signature: _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

[Retain this page in Patient records]

Privacy Notice Amendment September 2013

I have had the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use of my Personal Health Information.
Patient Name: _____

_____ _____
patient signature date

_____ _____
practice witness date

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