PATIENT INFORMATION

Patient Name:_____

Address:_____

SS#:_____ D.O.B._____

Phone #'s: Home:_____ Work:_____ Cell:_____

If Minor, Legal Guardian:_____

SS#:_____ D.O.B._____

Who May We Thank For Referring You? _____

Employer Name/Address:_____

E-mail Address _____

INSURANCE INFORMATION

PRIMARY

Subscriber's Name/Address:_____

Subscriber's SS#:_____ D.O.B._____

Relation to Patient:_____

Employer Name/Address: _____

Group #:_____

SECONDARY

Subscriber's Name/Address:_____

Subscriber's SS#:_____ D.O.B._____

Relation to Patient:_____

Employer Name/Address: _____

Group #:_____

I understand that I am financially responsible for all charges for services to me and my dependants, including the balance remaining after payment of possible insurance benefits.

Signed:_____ Date:_____

FINANCIAL INFORMATION

Payment is due and payable at the time services are rendered. We have several payment options available to accommodate our patients.

If you have insurance, we will estimate your co-payment which is due and payable at the time services are rendered. However, you must remember, this is just an estimate and after insurance pays there may be a remaining balance for which you are responsible.

Sometimes treatment we provide requires the use of a laboratory. These services necessitate payment of half down when the case is sent to the lab, with the remaining balance to be paid the day of insertion.

An annual finance charge of 18 percent is applied to any account balance 30 days or older. In case of default on payment, I am responsible to pay any legal interest on the balance due, any collection costs or attorney fees incurred during the collection of this account.

Signed:_____ Date:_____

HEALTH QUESTIONNAIRE

Name _____ Birth date _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time ..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No
   If so, explain _____
3. Does dental treatment make you nervous? No_____Slightly_____Moderately _____Extremely _____
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
   If so, when? _____
6. How often do you brush _____
   Brush is: Soft ☐ Medium ☐ Hard ☐
7. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blisters, lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

TEETH

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
If so, when_____		
Shifting in bite	Yes	No
Change in bite	Yes	No

8. Do you use the following?

Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No

Other _____

MEDICAL

1. Has there been any change in your general health within the past year ..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician ..... Yes No
   If so, what is the condition being treated _____
4. The name and address of my physician is _____
   _____
5. Have you had any serious illness within the past five (5) years ..... Yes No
   If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years ..... Yes No
   If so, what was the problem _____
7. Do you have or have you had any of the following diseases or problems
   a. Rheumatic fever or rheumatic heart disease ..... Yes No
   b. Congenital heart disease ..... Yes No
   c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) ..... Yes No
      1) Do you have pain in chest upon exertion ..... Yes No
      2) Are you ever short of breath after mild exercise ..... Yes No
      3) Do your ankles swell ..... Yes No
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep ..... Yes No
   d. Artificial or replacement valves ..... Yes No
   e. Pacemaker ..... Yes No
   f. Allergy ..... Yes No
   g. Sinus trouble ..... Yes No
   h. Asthma or hay fever ..... Yes No
   i. Hives or a skin rash ..... Yes No
   j. Fainting spells or seizures ..... Yes No
   k. Diabetes ..... Yes No
      1) Do you have to urinate (pass water) more than six times a day ..... Yes No
      2) Are you thirsty much of the time ..... Yes No
      3) Does your mouth frequently become dry ..... Yes No

(over)

l. Hepatitis, jaundice or liver disease ..... Yes No
m. Arthritis or inflammatory rheumatism ..... Yes No
n. Artificial or replacement joints, prosthetic ..... Yes No
o. Digestive system—Ulcers or stomach disorders (colitis) ..... Yes No
p. Kidney trouble ..... Yes No
q. Tuberculosis ..... Yes No
r. Persistent cough or cough up blood ..... Yes No
s. Immune System disorders (including AIDS, HIV, ARC) ..... Yes No
t. Venereal disease ..... Yes No
u. Other _____ Yes No

8. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma ..... Yes No
   a. Do you bruise easily ..... Yes No
   b. Have you ever required a blood transfusion ..... Yes No
   If so, explain the circumstances & when _____
9. Have you ever tested positive for the AIDS virus ..... Yes No
10. Do you have any blood disorder such as anemia ..... Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition ..... Yes No
12. Are you taking any of the following:
   a. Antibiotics or sulfa drugs ..... Yes No
   b. Anticoagulants (blood thinners) ..... Yes No
   c. Medicine for high blood pressure ..... Yes No
   d. Cortisone (steroids) ..... Yes No
   e. Tranquilizers ..... Yes No
   f. Antihistamines ..... Yes No
   g. Aspirin ..... Yes No
   h. Insulin, tolbutamide (Orinase) or similar drug for diabetes ..... Yes No
   i. Digitalis or drugs for heart trouble ..... Yes No
   j. Nitroglycerin ..... Yes No
   k. Other medications _____ Yes No
   l. If "Yes" to any of the above, state drug name, dosage and frequency _____
13. Are you allergic or have you reacted adversely to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Sulfa drugs ..... Yes No
   d. Barbiturates, sedatives, or sleeping pills ..... Yes No
   e. Aspirin ..... Yes No
   f. Iodine ..... Yes No
   g. Codeine or other narcotics Yes No
   h. Other _____ Yes No
14. Do you use any tobacco products ..... Yes No
   If so, how much per day and what _____
15. Do you use any alcohol products ..... Yes No
   If so, how much per day/week/month and what _____
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) ..... Yes No
   If so, how much per day and what _____
17. Do you have any disease, condition, or problem not listed above that you think I should know about ..... Yes No
   If so, explain _____
   _____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation ..... Yes No
19. Are you wearing contact lenses ..... Yes No
20. Are you experiencing stress or pressure in your work or at home ..... Yes No

WOMEN

21. Are you pregnant ..... Yes No
22. Do you have PMS or problems associated with your menstrual period ..... Yes No
23. Are you taking birth control or hormone therapy ..... Yes No

Remarks:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient Date Signature of Dentist Date

OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice.

Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also have a payment plan called CareCredit, that allows you to start treatment today and spread payments over time.

Payment Options

1. **Cash or Check**
2. **Major Credit Cards**
3. **CareCredit**

Applying for CareCredit only takes a few minutes and there is no fee to apply.

Please indicate below the form of payment you choose to settle your account: check one

- ❑ **Cash or Check**
- ❑ **Major Credit Card**
- ❑ **CareCredit (Subject to credit approval). If credit application is declined, another form of payment listed above is required.**

_____ _____

Signature of Patient/Responsible Party *Date*

Dr David A Najar

1514 N WALKER ST | PRINCETON WV, 24740 | (304) 487-3711

Written Financial Policy

Thank you for choosing Dr David A Najar. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card

We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with cash, check or credit card prior to completion of care for treatment plans of $1000 or more.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Dr David A Najar requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

We accept payment in thirds for treatments under $6500. For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $500 or more, a 1/3 deposit is required to secure your initial treatment appointment.

We also offer in-house financing for treatments under $2500. We charge 18% interest on all past due accounts.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $25 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice.

Dr David A Najar charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature Date:_____

Patient Name (Please Print) : _____

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent 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)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20 _____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

David A. Najar, D.D.S. Family Dentistry
1514 North Walker Street
Princeton, WV 24740