

Dr. Holly Nadji, DMD

www.GentleLadyDentist.com

NEW PATIENT REGISTRATION FORM

Patient's Personal Information

First Name: _____ Last Name: _____ D.O.B.: _____ Age: _____

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

Home Phone: _____ Cell/Pager: _____ Work Phone: _____ Ext.: _____

Email: _____

Sex: M F Marital Status: Single Married Divorced So. Sec.#: _____ (for processing insurance claims)

Employer: _____ Occupation: _____ How Long: _____

Address, City, State, Zip: _____

Financial Information

Person Responsible for Account: First Name: _____ Last Name: _____

Relationship to Patient: _____ D.O.B.: _____ Age: _____

Address (if different from patient): _____

Home Phone: _____ Cell/Pager: _____ Work Phone: _____ Ext.: _____

Soc.Sec.#: _____ Employer: _____ Occupation: _____

Please Tell Us More About You

Is another member of your family or relative a patient in our office? Name: _____ Relationship: _____

Who may we thank for referring you to our office? Name: _____ or Source: _____

If married, what is your spouse's name? _____ Phone #: _____

Whom should we contact in case of emergency? Name: _____ Relationship: _____

Address: _____ Phone #: _____

Dr. Holly Nadji, DMD

www.GentleLadyDentist.com

Dental History

1. Name of your last dentist: _____ City and State: _____
2. Date of your last dental cleaning _____
3. **Are you experiencing pain?** If yes circle which:
A. Upper Tooth G. Throbbing/pulsating
B. Lower Tooth H. Dull ache but constant
C. Left Side I. When Eating/drinking
D. Right Side J. With Hot/Cold
E. Toward the Back
F. Toward the Front
4. **Are you experiencing headaches and TMJ pain?** If yes, how often?
_____ Where _____
5. **Is there a family history of early tooth loss and periodontal or gum disease?** Y or N If so who? _____
What age did they lose teeth? ____ Why? _____
6. **Have you been diagnosed with gum disease?** _____ If yes when? _____
By which dentist? _____
Have you treated the disease? Y or N
7. **Any bleeding gums when you brush or floss?** Y or N. If yes where? _____
9. **Do you have any pain when you clench your teeth?** If yes, _____ where ?

10. **Have your last dentist's recommendations been completed by you?** Y or N. If no, why?
Money, Fear, Pain, Time.
If yes when where the recommendations completed? (month/date) _____
11. **What do you wish to accomplish with today's visit?**

Patient / Parent / Responsible Party Signature: _____ **Date:** _____

Dr. Signature: _____ **Date:** _____

Dr. Holly Nadji, DMD

www.GentleLadyDentist.com

INSURANCE INFORMATION

____ I do not have insurance (for your convenience, we accept Visa, MC and Discover card)

____ I have insurance (we will need to make a copy of your insurance card and drivers license)

I understand that I'm responsible for all amounts not covered by my insurance company.

Patient / Parent / Responsible Party Signature: _____ Date: _____

Dr. Holly Nadji, DMD

www.GentleLadyDentist.com

PAYMENT POLICY

In order to keep down treatment costs and provide the most optimal dental care possible we have established the following policies. We ask that you take a few minutes to read and sign below to acknowledge your acceptance of these policies. We appreciate your cooperation and thank you for allowing us to help maintain your dental health.

Payment is expected upon your arrival to the office, which you will know based on the estimate we gave you. Prior to each visit you will be presented with an estimate of your expected portion for your next visit. Payment is accepted in the form of cash, checks (except for first time patients), MasterCard, Visa, Discover. For your convenience we also provide affordable monthly payment plan options for larger procedures, which will allow you to have any necessary or desirable treatment done now and pay for it over time through Care Credit and Chase financing with approved credit. Please see one of the front office staff for more information about these options.

DENTAL INSURANCE

Please understand that your insurance is a contract between you, your employer and the insurance company. We are not a part of this contract. As a courtesy, Dr. Holly Nadji's staff will bill your insurance company. However, if we do not hear from them within 30 days of billing, the balance will become your responsibility and is to be paid in full. The responsibility will become yours to collect your reimbursement from your insurance company. "Usual and customary rates" means that an insurance company has a limit upon the amount it will pay on a procedure. Our fees reflect the quality of care our patients receive. Some insurance companies may pay on a much lower fee scale than others. The patient is responsible for any amount remaining after the insurance has paid its portion. We regret that we are unable to become involved in disputes between you and your insurance company regarding usual and customary rates, deductibles, or covered charges, other than to provide factual information.

FINANCIAL AGREEMENT and INSURANCE RELEASE

I have read and acknowledge and agree to the above policies. All information furnished by me is correct to the best of my knowledge. I authorize release of all pertinent information to my insurance company. I also authorize my insurance company to pay directly to Dr. Holly Nadji, the benefits to which I am otherwise entitled, if they have been assigned. I understand that when I undertake treatment in this office, I am responsible for all fees incurred and agree to pay for services rendered, regardless of my insurance benefits. I understand and agree that any information provided to me by this office regarding my insurance benefits is an "estimate" based on information received about my particular benefit contract, and not a guarantee of payment. I understand and agree to be responsible for payment of any balance remaining after Dr. Holly Nadji receives expected insurance benefits.

- **Statements:** If there is a balance due, you will only receive one statement from us. After the one statement you will receive a courtesy phone call and after the phone call, your account will be sent to our collection agency and all collection agency and attorney fees will be your responsibility.

- **X-ray Release:**

In the event you wish to have your x-rays digitally sent to another dentist or put on CD, we will gladly do so upon a fee of \$40 being paid and a consent form being signed. It does take **2 weeks** to prepare x-rays for transmission.

I understand a \$40.00 fee assessed on all returned checks. I agree to be responsible for all attorneys' fees, court costs, and collection agency fees if my account is sent to an attorney for collection, or referred to a collection agency.

Patient / Parent / Responsible Party Signature: _____ **Date:** _____

Witness(doctor's office) : _____ **Date:** _____

Dr. Holly Nadji, DMD

www.GentleLadyDentist.com

Cancellation / No Show Policy

In order to be fair to our loyal patients who are waiting for sooner appointment times, as well as those patients who keep their scheduled appointments, any appointments broken or cancelled without the required **72-hour notice** not including weekends or holidays will incur a fee of **\$25.00 per-half-hour** of scheduled time.

We understand that emergencies do sometimes occur and we ask to be notified as soon as possible if you are unable to make your appointment so we can help our other patients who are waiting for appointment times.

I understand the 72-hour notice.

Patient / Parent / Responsible Party Signature: _____ **Date:** _____

Dr. Holly Nadji, DMD

www.GentleLadyDentist.com

Notice of Privacy Practices **Patient Acknowledgement**

I have read and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the items of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon my request.

Relationship to patient (if signed by a personal representative of patient): _____

Patient / Parent / Responsible Party Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$50 for each page, \$20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003.

If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact:
Telephone: (904) 731-1919
Address: 7807 Baymeadows Rd., East, Suite 206
Jacksonville, FL 32256

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association. This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).