PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST, FIRST MI	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP	E-MAIL

MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

SPOUSE'S NAME LAST, FIRST MI	SPOUSE'S EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP

HOME PHONE #	WORK PHONE #	CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
Contact me at home	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via e-mail	☐	☐
Leave messages on my home voicemail / answering machine	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave messages on my work voicemail / answering machine	☐	☐

PLEASE PRINT

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

SECONDARY COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers	☐	☐	1.
Insurance Companies	☐	☐	2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE

Tribeca Dental Clinique

Azar Boujaran, D.D.S

123 Chambers Street

New York, NY 10007

212.587.0000

Name: _____ **Date:** _____

PRIVACY NOTICE

Your Privacy is Important

Azar Boujaran, D.D.S, understands your privacy is important. You have received this notice in accordance with applicable state and federal laws and because you are a current or potential patient. This notice will help you understand what types of non-public personal information - information about you that is not publicly available - we may collect how we use it and how we protect your privacy.

This is a summary of our Privacy Practices - if you would like more information, please inquire with the doctor or the receptionist.

Azar Boujaran, D.D.S Privacy Policy Highlights

1. We collect non-public personal information to process and administer our patients' business.
2. We have policies and procedures in place to protect non-public personal information about our patients or their families.
3. We do not sell non-public personal information about our patients or their families to third parties, i.e., companies or individuals that are not affiliated with us.
4. We do not disclose any non-public personal information about our patients or their families to anyone, except as permitted by law.
5. We disclose your private health information routinely to insurance companies, other providers, and others for purposes of treatment, payment and healthcare operations.
6. For all other purposes, we will either obtain your authorization or remove all information that could identify you as an individual.
7. Our Privacy Policy applies to both current and former patients.

Questions and Answers

That detail Azar Boujaran, D.D.S, Privacy Policy

What types of non-public personal information does Azar Boujaran, D.D.S collect?

Azar Boujaran, D.D.S, employees, representatives, agents and selected third parties may collect non-public personal information about our patients or their families, including:

1. Information provided to us, such as on applications or other forms.
2. Information about transactions with affiliates, our third parties or us.
3. Information from others, such as credit reporting agencies, employers and federal and state agencies.

The types of non-public personal information Azar Boujaran, D.D.S, collects vary according to the product or services provided and may include, for example: account balances, insurance premiums, marital status and health history.

What does Azar Boujaran, D.D.S, do to protect non-public personal information?

We restrict access to non-public information to those employees, agents, representatives, or third parties who need to know the information to provide products and services to our patients or their families. We have policies and produces that give direction to our employees, and agents and representatives acting on our behalf, regarding how to protect and use non-public personal information.

We maintain physical, electronic, and procedural safeguards to protect non-public personal information.

With whom does Azar Boujaran, D.D.S, share non-public personal information, and why?

We do not share non-public personal information about our patients or their families with anyone, including other affiliated companies or third parties, except as permitted by law. We may disclose, as allowed by law, all types of non-public personal information we collect when needed, to affiliated companies, agents, employees, representatives and third parties that market or services and products and administer and service customer accounts on our behalf. Examples of the types of companies and individuals to whom we may disclose non-public information include attorneys, trustees, third party administrators, insurance agents, and insurance companies, insurance support organizations, credit reporting agencies, registered broker/dealers, auditors and regulators. We do not share personally identifiable health information unless the customer or the applicable law authorizes further sharing.

Does Azar Boujaran, D.D.S's Privacy Policy apply to its agents and representatives?

Azar Boujaran, D.D.S's Privacy Policy applies, to the extent required by law, to its agents and representatives when they are acting on behalf of Azar Boujaran, D.D.S.

Please Note: There may be instances when these same agents and representatives may not be acting on behalf of Azar Boujaran, D.D.S, in which case they may collect non-public personal information on their own behalf or on behalf of another. In these instances, Azar Boujaran, D.D.S's Privacy Policy would not apply.

Will Azar Boujaran, D.D.S's Privacy Policy change?

Azar Boujaran, D.D.S reserves the right to change any of its privacy policies and related procedures at any time in accordance with applicable federal and state laws. You will receive appropriate notice if our Privacy Policy changes.

I hereby acknowledge that I have been presented with a copy of Azar Boujaran, D.D.S's Notice of Privacy Practices.

Date _____ Signature: _____

Tribeca Dental Clinique

Azar Boujaran, D.D.S

123 Chambers Street
New York, NY 10007
212/587.0000
fax 212/587.0033

Financial Agreement

Name: _____

PLEASE NOTE: Our office does accept assignment of insurance benefits as partial payment. Our acceptance does not absolve the responsible party of full responsibility for charges for treatment rendered. The estimate provided by our office is to be considered a guideline. We make every effort to be accurate in our estimation of benefits. However, since there is no way to be sure benefits have not been used in other offices or that the policy is in effect at the time of service, this office can make no guarantee of the insurance payment as estimated. Your benefits are between you and your insurance carrier(s). Claims are submitted promptly after treatment is rendered. If your insurance hasn't paid within two billing cycles of submitted charges the charges will be considered your responsibility and payment in full is expected from the responsible party. We take great pride in helping you receive the maximum benefit from your insurance. We are always glad to answer your questions and help you in any way we can. DUE TO HIPPA requirements, we are unable to provide your 2nd insurance with your primary insurance EOB. We therefore need you to forward a copy of your EOB to your 2nd carrier. If you wish to fax the EOB, you may do so at our office if you wish. Your share of payment will be disclosed in advance.

Any appointments that need to be cancelled for any reason have to be done 48 hours in advance. We automatically charge $100 for all missed appointments. We require a CREDIT CARD Number to be kept on file. Please provide us with any MC, Visa or American Express Number and Expiration Date:

Type of card: _____ **Number:** _____ **Exp. Date:** _____

The patient/responsible party is responsible for total payment for procedures performed by Dr. Boujaran and her staff, including any balance not covered by insurance. I understand office policy requires my account be paid in full each month. If I desire or need to make monthly payments, application for payments needs to be made before the dental treatment has begun. All accounts are to be paid in full within 90 days of treatment regardless of insurance. **TO ALL PATIENTS THAT RECEIVE THE INSURANCE PAYMENTS THE CREDIT CARD THAT IS PLACED ON FILE WITH OUR OFFICE WILL AUTOMATICALY BE CHARGED FOR ANY AND ALL OUTSTANDING DEBT.** I agree to pay all collection costs. I understand additional late fees may be applied if my payment is not received within 30 days of the statement. I certify to have read, understood and agree to this.

_____Yes _____No

I understand by not agreeing to this Dr. Boujaran may refuse to see me and will require that I pay all fees at the time of treatment, including any portion that would be covered by insurance. All charges would be disclosed in advance of services and approval will be obtained on a per diem basis.

Signature: _____ **Date:** _____

DENTAL HISTORY

Name_____ Nickname_____ Age_____

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____How long have you been a patient?_____Months/Years

Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____

Date of most recent treatment (other than a cleaning) _____/_____/_____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ ☐ ☐
28. Do you place your tongue between your teeth or rest your teeth against your tongue? _____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
34. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____