REVIVE
NEUROMUSCULAR AESTHETIC DENTISTRY

PLEASE READ BEFORE FILLING OUT FORMS…

We appreciate your interest in our dental practice. You have probably noticed we are different from the average dental practice. When you visit our office you will find a unique and relaxing environment. Our treatments are designed to be painless, permanent and to exceed your expectations. We use the most recent technology and techniques our industry has to offer. Our biggest strength lies not only in the quality of our work, but in how you are treated as well.

Essentially, we are "three different offices" in one facility.

- **General Dentistry:** These are the services a patient would expect to see in an average dental office such as cleanings and fillings. We excel in this area by providing comfortable, permanent and predictable services.

- **Cosmetic Dentistry:** All dentists proclaim to offer "cosmetic services" but we have taken it to a new level. We use the best materials and techniques available to get the best results. We offer a complete range of procedures from whitening/bleaching to veneers and implants.

- **Functional Dentistry:** Also called neuromuscular dentistry (NMD). This assesses a patient's bite (how the upper and lower teeth fit together) and diagnoses any malfunction. Some common symptoms of a "bad bite" are jaw pain/soreness/stiffness, grinding of teeth, headaches, jaw clicking/popping/locking, and chipped/broken teeth. Correcting the bite helps the jaw stay in the proper position for optimal function and comfort. A more functional bite can even improve your appearance, smooth wrinkles and make you look younger.

When a patient allows us to combine all 3 areas of dentistry, we achieve the best results. Filling out the following questionnaire will help us understand what areas you are interested in. We are only here to show you what the possibilities are. The extent of treatment you receive whether it's all, some or none is always entirely your choice.

Today's Date _____

Name _____ Date of Birth _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Our office is not just an average dental office. We place a high emphasis on providing you with the very best care possible, the highest quality materials and most advanced techniques in dentistry for your present and future dental needs. Here are some things we'll be talking about at your first visit. These are issues you may not have considered before. Please take a few moments to think about and answer the following questions:

Are you having any areas of concern?_____ _____

Do you have any family or friends that already come to our office?_____

What do you already know about our office and what are your expectations? _____

_____

Tell us, in your opinion, what you think the present state of the health of your mouth is?

_____

How do you feel about the appearance of your face and smile? _____

How healthy do you want us to get your mouth? (please circle)

"Don't really care" Average The best it can be

Should you need treatment, at what point should we address it? (please circle)

When my tooth hurts or breaks When something is worsening When something isn't ideal

What quality of dentistry do you want us to recommend? (please circle)

"Just patch it" Average Ideal/the best

We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you? (please circle)

As a general dentist As a cosmetic dentist As a functional dentist

Tell us about your good dental experiences… _____

and the bad ones… _____

What caused you to leave your last dentist? _____

What would help you to trust us as your dental office? _____

_____

Has either time or fear ever been a factor in getting your dental work done? ____ Time ____ Fear

Is the cost of dental treatment a concern for you?_____

Did you know our office can help you obtain financing?_____ Would you like to know more about this option? _____

Is there any additional information you would like us to know? _____

REVIVE NEUROMUSCULAR & AESTHETIC DENTISTRY

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

❑ Male ❑ Female ❑ Single ❑ Married (Spouse's Name _____) ❑ Other _____

Date of Birth _____ Social Security # _____

Address _____ City/State _____ Zip_____

Home Phone _____ Cell Phone _____ Email _____

Emergency Contact _____ Relationship to Patient _____

Emergency Phone Number_____ Alternate Phone Number _____

EMPLOYMENT

Employer Name _____ Occupation _____

Address _____ City/State _____ Zip_____

Work Phone _____ Ext. _____

How did you find out about us? ❑ Another Patient, friend* ❑ Another Patient, relative* ❑ Dental office* ❑ Doctor office*

❑ Internet/Website ❑ Radio ❑ Magazine ❑ Foxhall Walk-in ❑ A New Me ❑ Yellow Page ❑ Newsletter Mailing

* Whom may we thank for referring you to our office? _____

HEALTH HISTORY

Are you taking any medication now, including regular dosages of aspirin? ❑ Yes ❑ No

If yes, please list name and dosage_____

Are you allergic to any medication or substance? ❑ Yes ❑ No If yes, please list _____

Indicate which of the following you have had, or have at present

____ AIDS/HIV
____ Anemia
____ Arthritis
____ Artificial Heart Valve
____ Artificial Joints
____ Asthma
____ Bell's Palsy
____ Blood Disease
____ Cancer
____ Clenching Jaw
____ Congenital Heart Disease
____ Depression
____ Deviation of Jaw to one side
____ Diabetes
____ Difficulty Chewing
____ Difficulty Swallowing
____ Ear Congestion
____ Epilepsy/Seizures
____ Excessive Bleeding
____ Facial Pain
____ Fainting
____ Glaucoma
____ Grinding Teeth
____ Growths
____ Heart Concerns
____ Heart Disease
____ Heart Murmur
____ Headaches
____ Hepatitis
____ High Blood Pressure
____ Insomnia/Frequent Waking
____ Jaw Clicking/ Popping
____ Jaw Locking
____ Jaw Joint Pain
____ Kidney Disease
____ Latex Sensitivity
____ Limited Jaw Movement
____ Limited Jaw Opening
____ Liver Disease/Jaundice
____ Loose Teeth
____ Lupus
____ Mitral Valve Prolapse
____ Mental Disorder
____ Multiple Sclerosis
____ Neck/Shoulder Pain
____ Nervous/Anxiety Disorder
____ Neurological Disorders
____ Pacemaker
____ Pain Behind Eyes
____ Posture Problems
____ Radiation/Chemotherapy
____ Ringing or Pain in Ears
____ Respiratory Problems
____ Rheumatic Fever
____ Rheumatism
____ Sensitive Teeth
____ Sickle Cell Disease
____ Sinus Problems
____ Stomach Problems
____ Stroke
____ Thyroid Disorder
____ Tingling in Arms/Fingers
____ Trigeminal Neuralgia
____ Tuberculosis
____ Tumors
____ Ulcers
____ Uncomfortable Bite (feels "off")
____ Visual Disturbances
____ Venereal Disease
____ Vertigo (Dizziness)
____ Worn or Cracked Teeth

Do you have or have you had any disease, condition or problem that was not listed? _____

_____

Have you been admitted to a hospital or needed emergency care within the past two years? ❑ Yes ❑ No

If yes, for what?_____

Have you been under the care of a medical doctor within the past two years? ❑ Yes ❑ No

If yes, for what? _____

Physician's Name _____ Phone #_____

Have you seen an ENT (ear, nose & throat doctor)? ❑ Yes ❑ No Chiropractor? ❑ Yes ❑ No Neurologist? ❑ Yes ❑ No

Have you had Cortisone therapy? ❑ Yes ❑ No If yes, when?_____ For how long?_____ Dosage _____

Have you ever had any cosmetic procedure(s)? ❑ Yes ❑ No If yes, please list?_____

Women: Are you Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

DENTAL HISTORY

When was your last dental visit? _____ What was done at that time? _____

Reason for **this** visit _____

Have you ever had any complications following dental treatment? ❑ Yes ❑ No If yes, please explain _____

_____

How often do you brush your teeth? _____ How often do you floss? _____

Do your gums bleed while brushing? ❑ Yes ❑ No Do your gums bleed while flossing? ❑ Yes ❑ No

Do your gums feel tender or swollen? ❑ Yes ❑ No Does floss shred when you use it? ❑ Yes ❑ No

Do you avoid brushing any part of your mouth because of pain? ❑ Yes ❑ No If yes, what part? _____

Do you feel sensitivity or twinges of pain when your teeth come in contact with:

a) hot foods or liquids like soup, coffee or tea? ❑ Yes ❑ No
b) cold foods or liquids like ice cream or cold water? ❑ Yes ❑ No
c) sweets such as candy, fruit or sweet desserts? ❑ Yes ❑ No
d) sours like lemons, limes, grapefruit, etc.? ❑ Yes ❑ No

Do you clench or grind your jaw while sleeping or during the day? ❑ Yes ❑ No Does your jaw ever feel tired? ❑ Yes ❑ No

Do you lose or break fillings? ❑ Yes ❑ No Have you had braces? ❑ Yes ❑ No

Does your breath concern you? ❑ Yes ❑ No Do you smoke or chew tobacco? ❑ Yes ❑ No

Are you familiar with the term "preventive" dentistry? ❑ Yes ❑ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, all of the answers and information provided are true and correct. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. If I ever have any change in my health or medication, I will inform Dr. Yazdani at the next appointment without fail.

➔ Signature of Patient, Parent or Guardian _____ Date_____

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 cost 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. All fee estimates are valid only for a period of 6 months from the date of the exam or consultation.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office does not render services on the assumption that our charges will be paid by an insurance company. Any account with an unpaid balance exceeding 60 days will incur a service charge of 1 ½% per month (18% per annum) unless previous written financial arrangements were made.

In consideration for the 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/her assignee, at the time said services are rendered, or within 5 days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be 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 the Doctor or his/her assignee to telephone me at home or at my work to discuss matters related to this form.

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

➔ _____ Date _____

Signature of Guarantor of Payment/Responsible Party

REVIVE NEUROMUSCULAR & AESTHETIC DENTISTRY

FINANCIAL & PAYMENT POLICY

Payment for services performed:
We accept MasterCard, Visa, American Express, Discover and cash for payment of services. Established patients may also use personal checks. Additionally, we offer assistance applying for dental financing, some of which can be interest-free depending on the cost of treatment and type of payment plan selected.

Using dental insurance:
All co-pays, deductibles and non-covered procedures are the patient's responsibility and must be paid at the time service is rendered.

We will assist you with filing claims and obtaining the maximum benefits available under the terms of your policy. However, please be aware that **certain procedures and services may not be covered** as dental insurance is designed to **reduce** your cost but **not to eliminate it**. Also, please understand that your insurance is a contract between you and your insurance company; therefore, it is **your responsibility to learn about your policy's coverage and exclusions. It is also your responsibility to make sure we are in-network with your specific plan and to provide us with correct/current insurance information at least two (2) days prior to your appointment.** If you fail to do so, then you agree to be responsible for 100% of our regular office fees for that visit.

To expedite processing time, we will work with your insurance company to ensure that our services are billed properly and that all necessary information is submitted with claims. Most insurance carriers are required to pay physicians within 30 days; however, the ultimate responsibility for timely payment of services lies with the patient. After 30 days, any outstanding account balance due to unpaid insurance claims will become your responsibility and payment will be expected upon receipt of a statement.

We will assist with submitting claims to your primary dental insurance company only. You will be responsible for submitting claims to any supplemental or secondary insurance policy you may have.

Obtaining copies of your dental records:
In accordance with District of Columbia law and HIPPA regulation (45 C.F.R. § 164.524) **our office is required to maintain all original X-ray films**, however, copies of X-ray films can be made with a **duplication fee of $50.00 per set.** A copy of chart records (excluding X-rays) can be made with a **duplication fee of $20.00 per person**. **You must submit written consent** for the release of all records and allow up to 30 days for processing.

Returned checks and delinquent account balances:
There will be a $50.00 fee for returned checks and a $100.00 fee for cancelled checks. A warrant-in-debt will be filed with the District of Columbia Federal Court for any returned or cancelled checks not re-paid within five business days. Any account balance exceeding 30 days without payment arrangements will incur a late fee at the rate of 1.5 % every month until the balance is paid in full. Any account balance exceeding 90 days without payment arrangements will be sent to collections, and you will be responsible for all collections fees, attorneys' fees and court costs.

Cancellation policy:
Appointment times are exclusively reserved for each patient. Please respect this by giving 48-hours advanced notice for any appointment you need to change or cancel. Failure to notify us within 48 hours will result in a missed appointment charge of $150.00. If you miss more than one scheduled appointment you will be asked to secure the reservation of future appointments with a credit card. Also, if you arrive more than 15 minutes late your appointment will need to be rescheduled as it is unfair to keep the next patient waiting to be seen.

As a courtesy service we will do our best to make reminder/confirmation calls prior to appointments, but please understand that this is not always possible and it is your responsibility to remember appointment dates and times.

I HAVE READ AND UNDERSTAND THIS FINANCIAL / PAYMENT POLICY. I AGREE TO THE TERMS AND ACCEPT THE RESPONSIBILITIES AS DESCRIBED ABOVE.

➔ _____ ➔ _____

Signature of Patient, Parent or Guardian Date

➔ _____

Printed Name

REVIVE NEUROMUSCULAR & AESTHETIC DENTISTRY

HIPPA CONSENT AGREEMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require that health care providers obtain a consent agreement as it relates to the use and disclosure of individually identifiable health information (IIHI), but many practices will continue to use the Consent Agreement for other purposes.

Though not necessary to have your consent to allow us to use or disclose your IIHI to others who will treat you or support in providing you quality health care services, it is important to have your consent to use or disclose your IIHI to health care plans to insure accurate and timely payment for the services rendered. The law requires that we inform you of our policy regarding the protection of your IIHI through our Privacy Notice. We may already have a consent agreement from you. Please refer to our Privacy Notice for full explanation of how this office will protect your individually identifiable health information (IIHI).

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements.

I, _____ , have been presented with a Privacy Notice explaining my rights regarding my individually identifiable health information (IIHI). I consent to the use and /or disclosure of my IIHI for purposes of treatment, payment or other health care operations (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

➔ _____ ➔ _____

Signature of Patient, Parent or Guardian Date

➔ _____

Printed Name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have received a copy of the Privacy Notice.

➔ _____ ➔ _____

Signature of Patient, Parent or Guardian Date

➔ _____

Printed Name

REVIVE NEUROMUSCULAR & AESTHETIC DENTISTRY

HIPPA NOTICE OF PRIVACY ACT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review carefully:

How we may use and disclose your health information

1. **Treatment:** We may use and disclose health information for your treatment and to provide you with treatment related health care services.
2. **Payment:** We may use and disclose health information so that we or others may bill and receive payment from you, insurance company, or a third party for the treatments and services you received.
3. **Health Care Operations:** We may use and disclose health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office.
4. **Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services:** We may use and disclose health information to remind you of your appointment.
5. **Individuals Involved in Your Care or Payment for Your Care:** We may share health information with a person involved in your medical care or payment for your care such as family, close friends or a guardian.
6. **Research:** Under certain circumstance, we may use you and disclose health information for research purposes.

Special Situations

As required by Law: We may disclose health information as required to do so by international, federal, state or local law.
To Avert a Serious Threat to Health or Safety: We may use and disclose health information when necessary to prevent a serious threat to your health and safety or the safety and health of public or another person.
Business Associates: We may use and disclose health information to our business associates who function on our behalf or provide us with services such as billing.
Organ & Tissue Donation: If you are an organ donor, we may use or release health information to organizations that handles organ procurement, banking or transportation.
Military & Veterans: If you are a member of the armed forces, we may release health information as required by military command authorities.
Workers' Compensation: We may release health information for workers' compensation or similar programs.
Public Health Risks: We may disclose health information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report birth and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or condition; and report to appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.
Health Oversight Activities: We may disclose health information to health oversight agency for activities authorized by law.
Lawsuits & Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information in response to administrative order. We also may disclose health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Law Enforcement: We may release health information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons or similar process, 2) limited information to identify or locate a suspect, fugitive, material witness or missing person, 3) about the victim of a crime even if, under certain very limited circumstances we are unable to obtain the person's agreement, 4) about a death we believe may be the result of criminal conduct, 5) about criminal conduct on our premises, and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
Coroners, Medical Examiners & Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release health information to funeral directors as necessary for their duties.
National Security & Intelligence Activities: We may release health information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.
Protective Services for the President & Others: We may disclose health information to authorize federal officials so they may provide protection to the president, other authorized persons or foreign heads of state or to conduct special investigations.
Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the institution to provide you with health care, 2) to protect your health and safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding health information we have about you:

Right to Inspect & Copy: You have the right to inspect and copy health information that may be used to make decisions about your care or payment of your care. This includes medical and billing records. To inspect and copy this health information, you must make your request in writing to REVIVE Neuromuscular and Aesthetic Dentistry, 3301 New Mexico Avenue NW, Suite 108, Washington, DC 20016.
Right to Amend: If you feel that health information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing to REVIVE Neuromuscular and Aesthetic Dentistry.
Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of health information for purposes other than treatment, payment and health care operations for which you provided written authorization. To request an accounting of disclosures, you must make your request in writing to REVIVE Neuromuscular and Aesthetic Dentistry.
Right to Request Restrictions: You have the right to request a restriction of limitation on the health information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to REVIVE Neuromuscular and Aesthetic Dentistry. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
Right to Request Confidential Communication: You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request in writing to REVIVE Neuromuscular and Aesthetic Dentistry. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

REVIVE NEUROMUSCULAR & AESTHETIC DENTISTRY

INSURANCE & BILLING INFORMATION

GUARANTOR OF PAYMENT

Last Name _____ First Name _____ Middle _____

Date of Birth _____ Social Security # _____

Billing Address _____

Phone # _____ Relationship to Patient _____

INSURANCE INFORMATION

Some important concepts to remember:
Insurance is a contract between you and your insurance company.
Insurance benefits are always subject to review by your carrier
Your coverage is limited to the terms of your policy. Certain procedures and services may not be covered.
The information we are given by your insurance carrier is not a guarantee of payment

Insurance Company _____ Effective Date of Policy _____

Claims Mailing Address _____

Insurance Company Phone #:_____

Name of Patient:_____

Name of Insured _____ Relationship to Patient _____

I.D.# _____ Group # _____

Type of plan: PPO HMO/DMO Discount Plan POS Other_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of dental benefits to the office of Dr. Shila Yazdani and Dr. Michael Mortazie for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

PATIENT (Please print)_____ Date_____

PATIENT/GUARDIAN (Please print)_____ SIGNATURE_____