Bright Dentistry, Sherin Mostafa D.D.S.

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Information:

Patient name: ____ Date of birth: ___________________ Age:_______

SS #: ____ Male:_______ Female:_______ Child:_______

Married:_______ Single:_______ Divorced:_______ Widowed:_______

Home address: ____ City: ___________________ State: _______ Zip:__________

Billing address (if different): __________________________________ City: ___________________ State: _______ Zip:__________

Home phone: _____________________ Cell: _____________________ E-mail: ____

Employer/Occupation: ____ Bus. Phone: ___________________________________

Spouse's name: ______________________________________ Spouse's #:____

Emergency Contact: ___________________________________ Contact's #:_____________________________

Medical Information:

Name of your medical doctor: ___________________________________ Date of last visit to medical doctor: ___________________

Name of previous dentist: ____ Date of last visit to dentist: _________________________

Referred to us by: ____ Google Search ___Facebook ___ TV AD ___Personal Referral, if so whom__________________________

PLEASE READ AND SIGN:

I certify that the above information is correct. I also certify that any insurance payments will be assigned directly to Sherin Mostafa, DDS. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on any/all insurance submissions.

Print Name: ____ Signature: ____

I understand this office is no longer a Medicaid/Medicare provider.________ Initial Date: _____________________________

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐

Other ____________________

Notes: ____________________

____

____________________ Date: __________

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? ____________		
Do you smoke?	☐	☐
If so, how much? ____________		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe: ____________________

Please list all medications you are currently taking:

Medicine__________ Condition__________
Medicine__________ Condition__________
Medicine__________ Condition__________
Medicine__________ Condition__________
Medicine__________ Condition__________
Medicine__________ Condition__________
Medicine__________ Condition__________
Physician's Name__________ Phone__________
Address__________ Fax__________

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: ____________		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms? ____________		

Notes: ____________________

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Patient/Parent Signature: ____________________

Dentist Initial: ____________________

Bright Dentistry - Sherin Mostafa D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name:____

Address:____

Telephone:_______________________ E-mail:_______________________

SS#:_______________________

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Section B: TO THE PATIENT -- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice will be provided upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person(s): Front Desk
Telephone: (850)640-2162 Fax: (850)640-2163
E-Mail: info@brightdentistry.co
Address: 340 W. 23rd Street Panama City, FL 32405

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person(s) listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

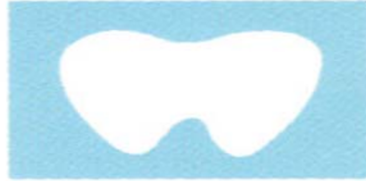
Signature: _______________________ **Date**:_______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_______________________

Relationship to the Patient: _______________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.



Bright Dentistry – Financial Policy

Our goal is to provide the highest quality of dental care possible and to have clear communication of our FINANCIAL POLICY.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE.

PAYMENT OPTIONS: We accept all major credit cards, debit cards, and cash. We also accept care credit.

PATIENTS WITH INSURANCE: Regardless of what we may calculate your insurance company to pay, **it is only an estimate**. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay. We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. If you would like to know an exact amount, we will give you a treatment plan so that you can call your insurance company and get a more accurate amount, or we can send your insurance company a Pre-Determination of Benefits request. Please note, Pre-Determinations can take anywhere from 3-4 weeks for your insurance company to process.

NO SHOW or LAST MINUTE CANCELATION POLICY: We reserve the right to charge a fee for a **NO SHOW** appointment or last minute cancelation. We appreciate a 24 hour notice for appointment changes. Patients who abuse this policy may be dismissed.

For All Patients:

I consent to the Doctor's exam and necessary diagnostics for treatment, including any x-rays.

Signature:____ Date: ____________________