Welcome To The General, Cosmetic, & Implant Dentistry Practice Of Mohamed Ali, DDS

To help us process your insurance correctly, please fill out this form completely and notify us of any change.
We will be happy to help if assistance is required.

PATIENT INFORMATION

First Name: ______ Last Name: ______ Middle Initial: ______ Mr./Mrs./Ms./Dr.

Preferred Name: ______ ☐ Male ☐ Female Date of Birth: / /

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Cell #: ______ Home #: ______ Work #: ______ Email: ______

Home Address: ______ City: ______ State: ______ Zip: ______

Minor: Yes/No Name of School: ______ Full-time Student: Yes/No

RESPONSIBLE PARTY INFORMATION

First Name: ______ Last Name: ______ Date of Birth: / /

Social Security #: ______ Relationship to Patient: ______

Cell #: ______ Home #: ______ Work #: ______ Email: ______

Home Address: ______ City: ______ State: ______ Zip: ______

Name of Employer: ______ Occupation: ______

Dental Insurance Company: ______ Dental Insurance Ph #: ______ Health Insurance Company: ______ Health Insurance Ph #: ______

ADDITIONAL INSURANCE INFORMATION

First Name: ______ Last Name: ______ Date of Birth: / /

Social Security #: ______ Relationship to Patient: ______

Cell #: ______ Home #: ______ Work #: ______ Email: ______

Home Address: ______ City: ______ State: ______ Zip: ______

Name of Employer: ______ Occupation: ______

Dental Insurance Company: ______ Dental Insurance Ph #: ______ Health Insurance Company: ______ Health Insurance Ph #: ______

WHO CAN WE THANK?

Referred by Friend: ______ Other (Please Specify): ______

AGREEMENT TO PAY

I understand that I am responsible for payment of services rendered and for paying any co-payment and deductible that my insurance does not cover. I hereby authorize payment directly to Mohamed Ali, DDS. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Patient Signature: ______ **Date:** ______

MEDICAL RECORD

First Name : ______ Last Name: ______ Date: / /

Do you have a personal physician? Yes / No | Physician's Name: ______ | Physician's Ph #: ______ | Date of Last Visit: / /

Travelled outside the U.S. in the last 6 months? Yes / No | Please specify where: ______ | For how long? ______

Anything you would like to discuss with the doctor in private? Yes / No

DENTAL HISTORY

Why have you come to the dentist today? ______

If you are a new patient, when was the last time you saw a dentist? ______ Why ? ______

Your current dental health is: *Good / Fair / Poor*

Have you ever taken *Phen – Phen / Redux & Pondimin*? *Yes / No*

Have you ever taken *Bisphosphonates*? *Yes / No*

Do you require antibiotics before dental treatment? *Yes / No*

Are your teeth sensitive to heat, cold, currently in pain? *Yes / No*

Have you ever had gum treatment or bleeding gums? *Yes / No*

Have you ever had a problem w/ any previous dental work? *Yes / No*

Have you ever experienced pain/discomfort in your jaw joint-TMJ? *Yes / No*

Do you like your smile? *Yes / No*

Do you like the shade of your teeth? *Yes / No*

Would you like your teeth to be whitened? *Yes / No*

ALLERGENS

☐ No known allergens ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Local anesthetics ☐ Penicillin ☐ Sedatives ☐ Sulfa drugs

☐ Antibiotics ☐ Barbiturates ☐ Erythromycin ☐ Latex ☐ Metals ☐ Plastic ☐ Sleeping pills ☐ Tetracycline

CURRENT MEDICATIONS

MEDICINE	DOSAGE / FREQUENCY	REASONS

Patient Signature: ______ **Date:** ______

MEDICAL HISTORY

MEDICAL CONDITION	NEVER	CURRENT	PAST	DATE/ NOTE	MEDICAL CONDITION	NEVER	CURRENT	PAST	DATE/ NOTE
Acid Reflux					Hospitalized				
Anemia					Hypertension				
Atherosclerosis					Hypoglycemia				
Arthritis					Immune System Disorder				
Asthma					Insomnia				
Autoimmune Disorder					Ischemic Heart Disease (reduced blood supply)				
Bleeding Easily					Kidney Problems				
Blood Pressure - High					Liver Disease				
Blood Pressure - Low					Meniere's Disease				
Bruising Easily					Metal Rods, Pins Or Implants				
Cancer					Mitral Valve Prolapse				
Chemotherapy					Mood Disorder				
Chronic Fatigue					Multiple Sclerosis				
Chronic Pain					Muscular Dystrophy				
COPD					Nasal Allergies				
Coronary Heart Disease					Neuralgia				
Current Pregnancy					Osteoarthritis				
Depression					Osteoporosis				
Diabetes					Parkinson's Disease				
Difficulty Sleeping					Prior Orthodontic Treatment				
Dizziness					Psychiatric Problems				
Emphysema					Radiation Treatment				
Epilepsy					Rheumatic Fever				
Excessive Daytime Sleepiness					Rheumatoid Arthritis				
Fibromyalgia					Shingles				
Frequent Headaches					Sickle Cell Disease/Traits				
Glaucoma					Sinus Problems				
Gout					Sleep Apnea				
Heart Attack					Stroke				
Heart Murmur					Tendency For Ear Infections				
Heart Pacemaker					Thyroid Disorder				
Heart Valve Replacement					Tuberculosis				
Hemophilia					Tumors				
Hepatitis					Ulcers				
Herpes / Fever Blisters					Urinary Disorders				

Other (Please Specify): ______________________________

Patient Signature: ______________________________ **Date:** / /

CONFIDENTAL MEDICAL HISTORY

MEDICAL CONDITION	NEVER	CURRENT	PAST	DATE/ NOTE	MEDICAL CONDITION	NEVER	CURRENT	PAST	DATE/ NOTE
Recreational Drugs					Other (Please Specify):				
HIV / AIDS					Other (Please Specify):				

SURGICAL OPERATIONS

☐ Appendectomy ☐ Ear ☐ Heart ☐ Lung ☐ Thyroid ☐ Uvulectomy ☐ Other:

☐ Back ☐ Gallbladder ☐ Hernia repair ☐ Nasal ☐ Tonsillectomy ☐ Periodontal ☐ Other:

FAMILY HISTORY

Has any member of your family (parent, sibling, or grandparent) had:

☐ Cancer ☐ Diabetes ☐ Stroke ☐ Obesity ☐ Father snores ☐ Father has sleep apnea

☐ Heart disease ☐ High blood pressure ☐ Sleep disorder ☐ Thyroid disorder ☐ Mother snores ☐ Mother has sleep apnea

SOCIAL HISTORY

Patient's Occupation: ________________ Employer: ________________

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker ☐ *# of packs per day* ☐ *# of years* ☐ Quit When? ________

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week: ☐

Caffeine Intake: ☐ None ☐ Coffee / Tea/ Soda # Cups / day ☐

Additional: ☐ Regular exercise

DECLARATION

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

I certify that the medical history information is complete and accurate.

I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Patient Signature: ________________ **Date:** / /

Doctor Signature: ________________ **Date:** / /

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

First Name: ______________________ Last Name: ______________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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.

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 accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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: Cherry Franco
Telephone: 415-391-7751
Fax: 415-391-7357

E-mail: info@malidds.com
Website: www.malidds.com
Address: 450 Sutter St., Ste 1905, San Francisco, CA 94108

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 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 to continue treating you if you revoke this Consent.

PRINT NAME

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 heath 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 Patient: ____________

You Are Entitled To A Copy Of This Consent After You Sign It. Include Completed Consent In The Patient's Chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________ **Date:** ____________

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

CONSENT FOR INTERNET COMMUNICATIONS

First Name: ______________ Last Name: ______________ Middle Initial: ____ Preferred Name: ______________

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature of patient, parent, or guardian:

Signature: ______________________________ **Date:** ______________

Relationship to Patient: ______________________ Date: ______________

ADJUNCTIVE ORAL ABNORMALITIES SCREENING FORM

Complete Each Time The Exam Is Offered And Place In Patient's File

*Oral cancer risks include:

- Tobacco use
- Chronic alcohol consumption
- Oral HPV 16/18 infection

This practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral abnormalities and their relationship with serious diseases such as oral cancer, and we do offer screenings for these warning signs to every patient.
Oral cancer is one of the deadliest diseases we encounter, and research shows that the late detection of oral cancer is the primary reason that mortality rates are so high[1]. As is the case with most other cancers, age is a primary risk factor for oral cancer. Tobacco use is also a major predisposing risk factor, however 1 in 4 who are diagnosed with oral cancer have no known risk factors*.
We find that using VELscope Vx – along with a visual examination – improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of abnormalities can minimize or eliminate the harmful and potentially disfiguring effects of serious oral diseases such as cancer and possibly save your life[1]. A painless exam gives us a better chance of finding any oral abnormalities you may have at an early stage. In our practice, the exam will be offered to you annually.
Dental insurance may or may not cover the exam, However, our office is happy to verify your coverage for you. We will also provide you with a medical insurance form to use to file this procedure with your medical insurance provider.

The fee for this exam is $ ______

☐ Yes. I authorize the clinician to perform the VELscope Vx exam along with the standard oral cancer examination. I accept financial responsibility for this exam.

☐ No. I would prefer not to have an oral abnormality screening exam at this time.

Print Name: ______________________

Signature: ______________________ **Date:** ____________

DenMat
1-800-4DenMat
(1-800-433-6628)
www.denmat.com
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[1]Data on file