PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female ◯ Unknown Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

Time 4:19 PM | Fary Yassamy, DDS | Date 12/7/2022

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

FaryYassamy DDS

Patient Expectation Agreement

We know that as a patient, you have a large array of choices when it comes to selecting the right dental practice for you. We appreciate you choosing us as your dental care provider. As a patient, you should expect nothing but the best for your dental office in terms of dental care, a welcoming and friendly atmosphere, and a respectful dental team. We strive to create your ideal office and hope to foster a relationship of mutual respect between patient and provider.

As a patient in our office, we will provide you with:

~ State of the art technology

~ Next Level in patient care

~ Digital X-rays (uses 70% less radiation)

~ General, cosmetic, preventive, implant, Invisalign, and TMJ Dentistry

~ Advanced treatment for gum and bone disease

~ Teeth whitening procedures

~ Gentle and caring team

~ All employees are highly educated

~ Soothing and attractive atmosphere

~ Patient comfort amenities menu

~ 24 hr. on call answering service

~ Free parking

~ Insurance billing for our patients

~ Financing available

As a patient of our office, we would appreciate the following.

~ Payment for treatment of service

~ Informing our office of changes to health, address, insurance, etc...

~ At least a 48 hour notification of appointment cancellation

~ On time arrival for scheduled appointments

~ Treat Doctor and staff members with courtesy and respect

We look forward to a long and happy relationship with you as our patient, Thank you again for choosing us as your dental team.

Patient Signature_____ Date_____

Doctor Signature_____Date_____

Fary Yassamy, DDS fary@faryyassamydds.com 825 Huntington Drive, San Marino, CA 91108 626.441.2231 fax 626.441.3024 www.faryyassamydds.com

FaryYassamy DDS

Financial Policy

Thank you for selecting us as your dental care provider. We are committed to the highest level of quality, preventive treatment. Please understand that payment for services rendered is part of your treatment. Outlined below is our financial policy. Please read it carefully and sign it before being seen by the doctor.

1. **Full payment is due at the time of service, unless previous arrangements have been made.**
2. **We accept cash, checks, Visa/MasterCard, American Express, and Discover.**
3. **If you have a dental benefit, you are expected to pay your estimated portion, all co-pays, or deductible at the time of service.**
4. **With prior arrangements, we offer an extended payment plan through an outside financing company.**

Our practice is committed to providing the best treatment for our patients, based on a diagnosis of what is needed to save and prevent further loss or damage to your gums or teeth. We charge fees that are usual and customary for our area. Our diagnosis will not be based on what your insurance company will cover, the amount of money you have left on your deductible, or how economical the treatment will be. Again, it will be based on what is in the best interest of your dental and health care. Regardless of any insurance company's arbitrary determination of what is usual and customary, you are responsible for payment.

If we are provided with all the necessary information, we will accept assignment of dental insurance benefits. This information must be provided before treatment begins. You will be expected to pay your estimated portion of the fee for treatment. ***Please be advised that this is only an estimate.*** The actual amount could vary depending on what your insurance will cover or unexpected changes in treatment. You are ultimately responsible for any balance for services rendered. Your insurance policy is a contract between your employer and your insurance company. We are not a party to that agreement. Until your insurance company has paid their portion of services rendered, the unpaid balance may appear on your monthly statement.

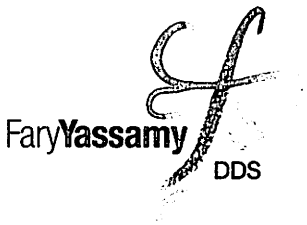
Appointment Policy

We make every attempt to schedule appointments for our patients in a manner that reduces any waiting time and provide prompt and attentive service to each and every patient. We do not double book appointments and make every effort to be ready for you at your scheduled appointment time. We expect our patients to respect their scheduled appointment times and make every effort to be as on time for us as we are for you.

We do require 48-hour notice for any appointment change. Failure to do so could result in a broken appointment *charge*. A broken appointment is a loss to you and prevents us from providing you with needed preventive and restorative care. It is a loss to the patient who could have had that appointment time. And it is a loss to our team who was fully prepared for your visit. Keeping your scheduled appointments and being on time is an important part of what contributes to our team providing the care our patients are accustomed to. We realize changes may need to be made occasionally, but we respectfully ask for your attention to this matter.

Patient_____ Date_____

Parent or Guardian_____ Relationship_____



Fary Yassamy, DDS, INC

825 Huntington Dr

San Marino, CA 91108

(626)441-2231

CANCELLATION POLICY

If for any reason you cannot make a scheduled appointment, please call our office at (626)441-2231. Our answering service is available after hours and on Saturday and Sunday. **WE DO CHARGE A FEE OF $50.00 for not showing up for an appointment without giving our office at least 48 hour notice.** This charger is to cover our downtime if we are unable to schedule someone else during that appointment time. (PLEASE Note: You are responsible for this $50.00 payment before or at your next visit. It is not covered by your insurance.)

Signed:_____ Date:_____

FaryYassamy DDS

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____, acknowledge that I have received from Dr. Fary Yassamy's office, a copy of the Dental Materials Fact Sheet.

_____ _____

Patient Signature Date

Consent for Use and Disclosure of Health Information

I hereby understand that I have certain rights to my privacy in regards to my protected health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) governs these rights. It is important for me to understand that the use of my health information be available for use by this office to accomplish three goals:

1. Providing treatment (including direct or indirect treatment by other healthcare providers involved in by treatment).
2. Obtaining payment from third party payers such as insurance companies.
3. Running day-to-day healthcare operations of this practice.

I am hereby informed that I have the right to review and secure a copy of the *Notice of Privacy Practices,* which contains a more detailed description for the uses and disclosures of my health information. Should the terms of this form be modified in any way as necessary by this office, a copy of it is available for my records.

I understand that it is my right to request restrictions on how my protected health information is used and disclosed to fulfill treatment, payment, and or healthcare operations, but that we are not required to comply with these restrictions. However, if we do agree to such request, we are bound under HIPAA to comply with the restrictions.

This consent hereby goes in effect upon the signing date of this form and will continue to such time unless revoked by myself in writing at any time. Any use of disclosure that occurred during this period is not affected by any outcome in which I have revoked this consent.

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Signature: _____

Relationship to Patient: _____

FaryYassamy DDS

ASSIGNMENT OF BENEFITS FORM

I, _____, understand that services rendered to me by Fary Yassamy, DDS are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Fary Yassamy, DDS and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFTIS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Fary Yassamy, DDS within 48 hours. I agree that if I fail to send the payment to Fary Yassamy, DDS and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the Insurance Company forward payment to me, I authorize Fary Yassamy, DDS to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize Fary Yassamy, DDS to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ **Witness**_____

_____ _____

Signature of policyholder **Patient or Guardian**

Fary Yassamy, DDS fary@faryyassamydds.com 825 Huntington Drive, San Marino, CA 91108 626.441.2231 fax 626.441.3024 www.faryyassamydds.com