Razen Natour
DMD, MScD
(212) 518 6494
Prosthodontics and Implant Surgery
www.simplyradiantsmile.com

Section 1: Patient Information

Patient Name: _____ Date:_____
Last First MI
How would you prefer to be addressed?_____ ☐ Male ☐ Female Age:_____

☐ Married ☐ Single ☐ Child ☐ Other Social Security #: _____Birth Date:_____

Phone (Home): _____(Work): _____Ext:_____ (Cellular):_____

Email: _____Emergency Contact & Tel#:_____

Address: _____
Street Apt/ Suite # City State Zip Code

Employer Name:_____Occupation:_____

Employer Address:_____
Street Suite # City State Zip Code

Other Family Members in Practice?_____ Whom may we thank for this referral?:_____

Section 2: Responsible Party Information

Is there another person responsible for your account and or subscriber with your dental insurance company? ☐ Yes ☐ No
(If No, Skip to Section 3)
If yes, name of responsible party:_____Relation:_____
Last First MI
Social Security #: _____ Birth Date:_____ Phone: _____

Address: _____
Street Apt/ Suite # City State Zip Code

Employer Name:_____Occupation:_____

Employer Address:_____
Street Suite # City State Zip Code

Section 3: Payment and Insurance Information

How will you be taken care of today's payment? _____Do you have dental insurance? ☐ Yes ☐ No
(If No, Skip to Section 4)

Primary Dental Insurance Information:

Name of Insurance Company:_____ Name of Subscriber:_____

Address:_____
Street Suite # City State Zip Code
ID#:_____ Employer Name:_____ Policy #:_____

Group#:_____ Telephone#_____ Zip Code:_____

Secondary Dental Insurance Information:

Name of Insurance Company:_____ Name of Subscriber:_____

Address:_____
Street Suite # City State Zip Code
ID#:_____ Employer Name:_____ Policy #:_____

Group#:_____ Telephone#_____ Zip Code:_____

Section 4: Consent for Services

I consent to the diagnostic procedures and treatment by Mazen Natour DMD and clinicians in this company, including but not limited to x-rays, study models, photographs, and any other tools to help the office make a clear diagnosis. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I understand that I can have a full copy of our Notice of Privacy Practices at any time it is requested but agree to this synopsis. I understand and consent to the office's use and disclosure of my records for treatment, payment or healthcare operations, and to me at my written request. I know that Mazen Natour DMD and clincians in this company will not disclose my private health information to anyone or any company for any other purpose unless we are required to do so by law.

I realize that the clinical findings after radiological examination are the recommendations to correct problems that exist with my teeth and oral tissues. All reasonable options, along with advantages and disadvantages will be discussed. It is my decision as to which treatment option I wish to pursue. Mazen Natour DMD and clinicians in this company will not be liable for treatment that is ignored or not completed due to my negligence, inability or refusal to have work performed.. Also I understand that during the course of treatment, additional unforeseen treatment may be required to properly treat my condition and any changes in treatment or cast will be discussed with me.

As a patient of this office, I understand that financial arrangements must be made in advance for any out of pocket costs prior to treatment being rendered. I understand that all emergency dental procedures without previous financial arrangements must be paid in full at time of service performed. I understand that fee estimates do expire after 6 months unless authorized by our office.

I authorize payment directly to the provider of service unless services were paid by me for insurance reimbursement. I understand that my dental insurance carrier or payor may pay less than the actual bill for services and that I am responsible for payment in full of all accounts. Although Mazen Natour DMD and clinicians in this company will assist you in all aspects of the insurance billing process, it is my responsibility to notify the office of any changes in information listed on file. I agree to be responsible for payment of services not paid by insurance carrier and payment not received for over 90 days can be sent to collection agency and/or possible legal action for collection of payment.

I attest to the accuracy of the information on this page and understand that false impersonation and representation of self for use of dental insurance or any other purpose is fraud and will be reported to the authorities as Identity Theft, a federal crime.

I understand that appointment times are reserved solely for me and it is my responsibility to cancel any appointments with Mazen Natour DMD and clinicians in this company with at least 48 hours (2 business day) notice. We do understand that emergencies and conflicts may arise but nonetheless our office reserves the right to charge $150 per hour for last minute cancelations. I understand that there will be a bank charge of $35 for any dishonored or checks returned unpaid. I grant permission to you or your assignee to contact me in any of the above methods to discuss matters related to this form or treatment.

I have read the above consent agreement and fully consent to Mazen Natour DMD and clinicians in this company's to this Consent of Services. I have been answered any questions that I may have regarding this form.

_____ Date:_____ Relationship to Patient: _____
Signature of patient, parent, or guardian

_____ Date:_____ Witness:_____
Print name

Section 5: Medical Health Information

Reason for this visit:_____ Date of Last Physical Examination:_____

If you certify that you are in good health, have absolutely no health problem, history of health problems, allergies of any kind, are not taking any medications, and (women only) are not pregnant, please initial here:_____, sign bottom of page and skip to Section 6.

Have you ever had any of the following? Please check those that apply:

☐ Abnormal Bleeding	☐ Chronic Pain	☐ Growths	☐ Mental Disorders	☐ Sinus Problems
☐ Acid Reflux	☐ Diabetes	☐ Head Injuries	☐ Nervous Disorders	☐ Sleep Disorders
☐ AIDS/ HIV	☐ Dizziness	☐ Hemophilia	☐ Neurological Disorders	☐ Sores / Ulcers in Mouth
☐ Anemia	☐ Eating Disorder	☐ Hepatitis	☐ Osteoporosis	☐ Stoke
☐ Arthritis	☐ Epilepsy/ Seizures	☐ High/ Low Blood Pressure	☐ Recurrent Infection	☐ Swollen Glands in Neck
☐ Artificial Joints	☐ Excessive Urination	☐ Jaundice	☐ Respiratory Problems	☐ Thyroid Problems
☐ Asthma	☐ Fainting	☐ Kidney Disease	☐ Severe Headaches	☐ Tuberculosis
☐ Blood Disease	☐ Gastrointestinal Disease	☐ Liver Disease	☐ Severe/ Rapid Weight Loss	☐ Tumors
☐ Cancer/ Radiation	☐ Glaucoma	☐ Lupus	☐ Sexual Transmitted Disease	☐ Ulcers

Are you under a physician's care? ☐ Yes ☐ No Physician's Name and Tel #:_____

Do you have any Cardiovascular Disease such as: Angina, Arteriosclerosis, Artificial Heart Valves, Congenital Heart Defects, Congestive Heart Failure, Coronary Artery Disease, Damaged Heart Valves, Heart Attack, Heart Murmur, Mitral Valve Prolapse, Pacemaker, Rheumatic Disease/ Fever, Chest Pain upon Exertion? ☐ Yes ☐ No
If yes, please explain:_____

Has a physician or previous dentist recommended that you take antibiotics before dental treatment? ☐ Yes ☐ No

Are you allergic to or had a reaction to any of the following: Local anesthetics, Aspirin, Penicillin, Clindamycin, Sulfa drugs, Codeine or other narcotics, Latex, Iodine, Seasonal Changes, Foods, Metals, or anything else not listed? ☐ Yes ☐ No
If yes, please specify and explain reaction:_____
_____

Have you had any serious illness or major surgery? ☐ Yes ☐ No If yes, please explain: _____
_____

Are you taking any medications? ☐ Yes ☐ No If yes, please list medications:_____
_____

Do you have any condition not listed above that you would like to discuss with the doctor? ☐ Yes ☐ No

Women Only: Are you pregnant, suspect you might be, or trying to be pregnant? ☐ Yes ☐ No
If yes, Due Date:_____ Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

I CERTIFY THAT THE ABOVE IINFORMATION IS COMPLETE AND ACCURATE

PATIENT/ GUARDIAN SIGNATURE:_____ DATE:_____

DENTIST'S SIGNATURE:_____ DATE:_____

Section 6: Dental Health Information

Purpose for Initial visit:_____ Date of last Dental Visit:_____

Previous Dentist Name and Telephone#:_____ Date of last dental x-rays:_____

Have you ever had or currently having any of the following? Please check those that apply:

☐ Dry Mouth	☐ History of Jaw Pain/ TMJ Disorder	☐ Bleeding Gums	☐ Uncomfortable Bite When Chewing	☐ Unpleasant Dental Experience
☐ Bad Breath	☐ Orthodontic/ Braces Treatment	☐ Frequent Gum Infections	☐ Chewing with one Area of Mouth	☐ Loose/ Missing Teeth
☐ Clenching/Grinding of teeth	☐ Endodontic/ Root Canal Treatment	☐ Swelling/ Irritation Of Gum Tissue	☐ Swelling/ Lumps in Mouth or Lips	☐ Chipped Teeth
☐ Food Impaction	☐ Periodontal / Gum Treatment	☐ Unpleasant Taste in Mouth	☐ Earaches or Neck Pain	☐ Crowded/ Overly Spaced Teeth
☐ Frequent Blisters/ Sores in mouth	☐ Sensitivity to hot or Cold	☐ Sensitivity to sweets Or pressure	☐ Wear Removable Dental Appliances	☐ Snoring or Sleep Apnea

Have you ever had any problems or complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

How often do you visit the dentist?_____ How often do you Brush?_____ Floss?_____

Are you unhappy with the appearance, color, and shape of your teeth? ☐ Yes ☐ No
If yes, please explain:_____

Are there old fillings or dental treatment that you aren't happy with? ☐ Yes ☐ No
If yes, please explain:_____

Do you smoke cigarettes, pipes, or cigars or chew tobacco? ☐ Yes ☐ No
If yes, how much daily and any plan on quiting?_____

Are you satisfied with the appearance of your smile? ☐ Yes ☐ No
If no, what can we do to help you achieve the smile you will be happy with? _____
_____
_____

I CERTIFY THAT THE ABOVE IINFORMATION IS COMPLETE AND ACCURATE

PATIENT/ GUARDIAN SIGNATURE:_____ DATE:_____

DENTIST'S SIGNATURE:_____ DATE:_____