Picasso Smiles DENTAL
COSMETIC & IMPLANT CENTER

REGISTRATION FORM HISTORY

Patient Information

Date _____

Name: _____ Date of Birth _____ SS # _____

Home phone # ( ) _____ Cell phone # ( ) _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Driver's License # _____ State _____ Email Address: _____

Check Appropriate Box: ____Minor ___Single ____Married ____Divorced ____Widowed ____Separated

If College Student: ____Full time ___Part time Please send me special promotions: ❑ Yes ❑ No

How did you hear about us? ____Billboard ____Flyer ____Newspaper ____Website ____Facebook

____I dreamt I should come here Referred by _____

Household Information or Responsible Party

Name: _____ Date of Birth _____ SS # _____

Home phone # ( ) _____ Cell phone # ( ) _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Driver's License # _____ State _____ Email Address: _____

Insurance Information

Name of Insured: _____ Date of Birth _____ SS # _____

Employer's Name _____ Employer's Phone ( ) _____

Name of Primary Insurance Co. _____ Insurance Co. Phone ( ) _____

Name of Secondary Insurance Co. _____ Insurance Co. Phone ( ) _____

This information I have given is true and correct. I authorize release of any information relating to my dental treatment to any and all insurance carrier's that may pay benefits for claims submitted for my dental treatment including those whom I am responsible for. _____ Signed (Responsible Party/Patient or Parent if Minor) Date	I hereby authorize payment from my insurance carrier of the dental benefits otherwise payable to me directly to Picasso Smile I understand that I am responsible for all cost or dental treatment whether or not my insurance pays for my or whom I am responsible for. _____ Signed (Insured Person) Date

1816 N. Zaragoza, Suite 103
El Paso, TX 79936
915-857-6453

Picasso Smiles DENTAL
COSMETIC & IMPLANT CENTER

255 Shadow Mountain, Suite H
El Paso, TX 79912
915-587-6453

MEDICAL / DENTAL HISTORY

Patient Name: _____ Birth Date _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	YES	NO
Are you under a physician's care now?	___	___
If yes, explain:_____		
Have you ever been hospitalized or had a major operation?	___	___
If yes, explain:_____		
Have you ever had a serious head or neck injury?	___	___
Are you taking any medication, pills, or drugs?	___	___
If yes, explain:_____		
_____		
_____		
_____		
_____		
Do you take, or have you taken, Phen-Fen or Redux?	___	___
Have you ever taken Fosamax, Boniva, Actonal or any other medications containing biaphosphonates?	___	___
Are you on a special diet?	___	___
Do you use tobacco?	___	___
Do you use controlled substances?	___	___

WOMEN:

Are you Pregnant/Trying to get Pregnant?	___	___
Taking oral contraceptives?	___	___
Nursing?	___	___

ALLERGIC TO ANY OF THE FOLLOWING?

❑ Aspiring ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal

❑ Latex ❑ Sulfa drugs ❑ Other _____

DO YOU HAVE OR HAVE YOU HAD, ANY OF THE FOLLOWING?

	YES	NO		YES	NO
AIDS/HIV Positive	___	___	Cortisone Medicine	___	___
Alzheimer's Disease	___	___	Diabetes	___	___
Anaphylaxis	___	___	Drug Addiction	___	___
Anemia	___	___	Easily Winded	___	___
Angina	___	___	Emphysema	___	___
Arthritis/Gout	___	___	Epilepsy or Seizures	___	___
Artificial Heart Valve	___	___	Excessive Bleeding	___	___
Artificial Joint	___	___	Excessive Thirst	___	___
Asthma	___	___	Fainting Spells/Dizziness	___	___
Blood Disease	___	___	Frequent Cough	___	___
Blood Transfusion	___	___	Frequent Diarrhea	___	___
Breathing Problem	___	___	Frequent Headaches	___	___
Bruise Easily	___	___	Genital Herpes	___	___
Cancer	___	___	Glaucoma	___	___
Chemotherapy	___	___	Hay Fever	___	___
Chest Pains	___	___	Heart Attack/Failure	___	___
Cold Sores/Fever Blisters	___	___	Heart Murmur	___	___
Congenital Heart Disorder	___	___	Heart Pacemaker	___	___
Convulsions	___	___	Heart Trouble/Disease	___	___
Hepatitis A, B, C	___	___	Recent Weight Loss	___	___
Herpes	___	___	Renal Dialysis	___	___

CONT.	YES	NO		YES	NO
High Blood Pressure	___	___	Rheumatic Fever	___	___
High Cholesterol	___	___	Rheumatism	___	___
Hives or Rash	___	___	Scarlet Fever	___	___
Hypoglycemia	___	___	Shingles	___	___
Irregular Heartbeat	___	___	Sickle Cell Disease	___	___
Kidney Problems	___	___	Sinus Trouble	___	___
Leukemia	___	___	Spina Bifida	___	___
Liver Disease	___	___	Stomach/Intestinal Disease	___	___
Low Blood Pressure	___	___	Stroke	___	___
Lung Disease	___	___	Swelling of Limbs	___	___
Mitral Valve Prolapse	___	___	Thyroid Disease	___	___
Osteoporosis	___	___	Tonsillitis	___	___
Pain in Jaw Joints	___	___	Tuberculosis	___	___
Parathyroid Disease	___	___	Tumors or Growths	___	___
Psychiatric Care	___	___	Ulcers	___	___
Yellow Jaundice	___	___	Venereal Disease	___	___

Any serious illness not listed above? _____

PATIENT DENTAL HISTORY

Reason for this visit _____

Date of last dental Visit _____ What was done? _____

Previous dentist name/location _____

Circle all that you are concerned about/currently have:

Tooth pain/ache	Sensitivity To:	Hot Cold Sweets
Cavities	Gum disease	Pain to bite
Broken teeth	Broken Fillings	Missing teeth
Dark teeth	Ugly teeth	Crooked teeth
Bad breath	Clicking jaw	Fear of dentists
Loose teeth	Spacing	Grinding/clenching
Jaw or face pain	Headaches	Want whiter teeth
Want to save teeth	Poor dentistry	Want gentle dentist
Dream teeth fall out	Recession	Cosmetic dentistry
Snoring/Apnea	Nothing	Bleeding gums

I am changing dentist because: Check any that apply

__ Recently moved into this area from _____

__ Dr/staff personality / Communication problem __ Inadequate care __ Fee concern

__ I'm fleeing managed care / don't want a "list" dentist

__ To find a dentist team who understands my needs

I have avoided dental care in the past because:

__ Fear of _____

__ Time commitment __ No perceived need __ Financial commitment __ Trust factor

If you could change anything about your smile, what would you change?

_____

Are you interested in exploring: Check any that apply

__ Invisalign invisible orthodontic aligners __ Bright smile and zoom

__ Info on helping snoring or sleep apnea in your home

__ Sedation Dentistry (taking a pill) options

__ Smile Makeover __ Smile Analysis and Design

__ Why dental infections cause heart and other diseases

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 Date

PATIENT CONSENT FORM
HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the term of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protect health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient name:_____

Relationship to Patient: _____

Signature: _____

DENTAL SERVICE ARBITRATION AGREEMENT

(The dentist whose name appears below) SHAYESTEH & SHAMS PA or SHAYESTEH & SHAMS WESTSIDE PA agree to provide to the undersigned patient dental, surgical and related health care services in consideration for the payment on a fee for service basis.

ARTICLE I

It is understood that any dispute as to dental malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE II

Said agreement for arbitration as provided in Article I above shall apply to any legal claim or civil action in connection with this dental service, including but not limited to disputes as to dental malpractice against this Picasso Smiles, its agents, representatives, employees, successors in interest and staff dentist of the dentist and the patient "whether or not a minor" his heirs-at-law, personal representatives and any claim in tort, contract or otherwise the other of demand for arbitration of any controversy, the parties to the controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after notice has been given, the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time of the date of the notice of the selection of the neutral arbitrator. All notices or other papers required to be served shall be served by US MAIL.

ARTICLE III

The Dentist named below agrees only to provide such services as in his opinion are reasonable, necessary and appropriate. Should patient for reasons personal to himself/herself refuse to accept the procedures, medicines or courses of treatment recommended by the dentist, and if the dentist believes that no professionally acceptable alternative exist, and after being so advised that patient still refuse to follow the recommended treatment or procedure, then the patient shall be given no further treatment and the dentist shall have no further responsibility to provide services specified herein for the condition under treatment.

ARTICLE IV

The execution of this Arbitration Agreement is not a precondition to the furnishing of service by the Picasso Smiles. This Arbitration Agreement may be rescinded by written notice from the Patient or Patient's representative to the Picasso Smiles within 30 days of signature and if no such notice is given, the agreement herein concerning arbitration shall be binding and compulsory. This Arbitration Agreement binds the parties and their heirs, representatives, executors, administrators, successors, and assigns.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Signature: _____ Date: _____

"Patient or Spouse or Parent"

Doctor: _____ Witness: _____

INSURANCE DISCLOSURES

As a courtesy to our insured patients Picasso Smiles Dental will accept assignment of your dental insurance toward your dental account under the following terms and conditions. Be assured that we will make every effort to **estimate** your benefits from the information provided to us by your insurance carrier.

I understand and accept that this is only an estimate and in the event of an underpayment or non payment from my insurance carrier, then I, the insured patient/responsible party will be responsible for the difference in monies of underpayment or payment in full if non payment. And clear any and all outstanding balances to my account.

_____

Patient/Parent/Responsible Party Signature Date

Furthermore:

(Please initial all agreements)

_____ I, the insured patient/responsible party accept full responsibility for my dental insurance carrier for any information they do or do not give to Picasso Smiles Dental when verifying dental benefits.

_____ I, the insured patient/responsible party understands and accept I am fully responsible for my account regardless of any underpayment or non payment from my insurance. This may be due in part or in whole to deductibles, co-payments, usual and customary fees, previously applied treatment, lack of coverage, or waiting period as governed by my insurance carrier.

_____ I, the insured patient/responsible party accepts full responsibility to follow up with any outstanding claims which my insurance carrier has not processed including cooperating with Picasso Smiles Dental in responding quickly to my insurance carrier in the event additional information is requested of me.

_____ I, the insured patient/responsible party understands that my account is due in its entire balance within 30 days regardless of payment or not payment made by my insurance carrier.

_____ I, the insured patient/responsible party have read and understand the terms and conditions and do not hold Picasso Smiles Dental responsible for any underpayment or non payment from my insurance carrier.

_____ I, the insured patient/responsible party understands that all disagreements on how my claims are paid or not paid are between me and my dental insurance carrier as I am the owner of the insurance policy and not Picasso Smiles Dental.

_____ If I, the insured patient/responsible party carry multiple insurances, will cooperate with Picasso Smiles Dental in the event that there is a conflict as to primary and secondary coverage.

I, the patient/responsible party accept full responsibility of my account balance regardless of insurance payments.

_____

Patient/Parent/Responsible Party Signature Date