Dental Team of Johns Creek
Dr. Zena Sadik-Yosif DDS
9950 Jones Bridge Road, Suite 700
Alpharetta, GA 30022
678-366-1000

PATIENT UPDATED INFORMATION

Name: (Last) (First) SS#

Street Address:

City: State: Zip Code:

Home#: Cell#: Email:

Date of Birth: Gender: M □ F □ Age:

Marital Status: □ Child (-18) □ Single (18+) □ Married □Widowed □ Separated

Patient Employed by: Occupation:

Guardian/Spouse's Name: Guardian/Spouse's #:

Date of Birth: Age: SS#:

Dental Insurance: ID #: GROUP #:

In case of emergency who should be notified? Phone #:

Date_____**Signature**_____

INSURANCE BENEFIT INFORMATION

The undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Zena Sadik-Yosif, D.M.D., M.S. all insurance benefits and payments, if any, for services rendered. I understand and agree that (regardless of my insurance status) I am financially responsible for all charges whether or not paid by insurance. I understand that Dental Team of Johns Creek files my insurance as a courtesy and it is my responsibility to know my individual insurance policy. I hereby authorize the doctor to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Relationship to patient Date

The Benefit Breakdown information that Dr. Zena Sadik-Yosif, D.M.D., M.S. has of _____ is only a Summary of Benefits, not a guarantee of payment. The information may not be accurate on the date the services are rendered and the insurance coverage is subject to change by decision of the insurance company. Payment of claim will only be considered, by the insurance company, when they receive and review of the claim.

_____ _____

Responsible Party Signature Relationship to patient Date

ASSIGNMENT AND RELEASE

The undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Zena Sadik-Yosif, D.M.D., M.S. all insurance benefits and payments, if any, for services rendered. I understand and agree that (regardless of my insurance status) I am financially responsible for all charges whether or not paid by insurance. I understand that Dental Team of Johns Creek files my insurance as a courtesy and it is my responsibility to know my individual insurance policy. I hereby authorize the doctor to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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Responsible Party Signature Relationship to patient Date

DENTAL HEALTH HISTORY

Reason for your visit today _____ Date of last dental visit: _____
Previous dental office/provider _____ Date of last x-rays: _____
Are you satisfied with your smile? ☐ yes ☐ no
How often do you brush your teeth? ☐ rarely ☐ 1x a day ☐ 2x a day
How often do you use dental floss? ☐ rarely ☐ 1x a day ☐ 2x a day

MEDICAL HISTORY

Primary Care Provider: _____ Date of last visit: _____
Are you being monitored by a specialist ☐ yes ☐ no Please list why: _____

How often do you drink alcohol? ☐ never ☐ rarely ☐ socially ☐ frequently
How often do you smoke/vape? ☐ never ☐ rarely ☐ socially ☐ frequently
Do you consume recreational drugs? ☐ never ☐ rarely ☐ socially ☐ frequently
Have you ever had a blood transfusion? ☐ yes ☐ no If yes, please list when: _____
Have you ever taken any of the following medications? (Please mark ✔ on all that apply)
☐ Bisphosphonates ☐ Fosamax ☐ Actonel ☐ Atelvia ☐ Didronel ☐ Boniva ☐ Apidex ☐ Fastin ☐ Pondimin ☐ Redux
Please explain why previous medications were used: _____

Please mark ✔ on all that apply

☐ Anemia ☐ Back problems ☐ Blood clotting problems ☐ Headaches
☐ Arthritis ☐ Cancer ☐ Chemotherapy ☐ Chemical Dependencies
☐ Circulatory problems
☐ Artificial heart valves
☐ Artificial joints
☐ Asthma ☐ Cancer ☐ Chemotherapy ☐ Chemical Dependencies ☐ Circulatory problems
☐ Cortisone Treatments ☐ Coughing blood ☐ Diabetes type 1
☐ Diabetes type 2 ☐ Epilepsy ☐ Fainting spells ☐ Gastric Bypass
☐ Glaucoma Pacemaker ☐ Heart attack ☐ Heart problems
☐ High blood pressure ☐ Hepatitis
☐ Hemophilia ☐ Kidney problems ☐ Intestine problems
☐ Mitral valve prolapse
☐ Persistent cough ☐ Tonsillitis ☐ Radiation treatment ☐ Respiratory infections
☐ Rheumatic fever ☐ Difficulty breathing ☐ Cutaneous treatments
☐ Stroke ☐ Scarlet fever ☐ Swelling of feet/ankles
☐ Thyroid problems ☐ Tuberculosis
☐ Ulcers ☐ Venereal disease

MEDICATIONS

List any medications you are currently taking:

_____

_____

Pharmacy name:_____
Phone:_____

ALLERGIES

□ Aspirin □ Penicillin
□ Barbiturates (sleeping pills) □ Sulfa
□ Codeine □ Other_____
□ Local Anesthetic _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____Signature_____

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OFFICE POLICY AND FINANCIAL AGREEMENT

Welcome to Dental Team of Johns Creek, the office of Dr. Zena Sadik-Yosif. It is our pleasure to serve your dental needs! We would like to take this opportunity to thank you for trusting us with your dental care. At our practice we strive to offer quality dentistry with a gentle touch in a friendly, caring atmosphere. Please note that your time is important to us. Our office hours are between 8:00 and 5:00 Monday through Thursday, and 8:00 to 12:00 on Friday.

APPOINTMENTS

Once an appointment has been made, it is your responsibility to keep that appointment. We ask that you give us as much notice as possible when changing your appointment time so we may offer the time to another patient. There is a **minimum charge of $50.00** for each broken appointment with **less than the 48-hour notice**. If you confirm your appointment and cancel the same day you will also be **charged for a fee of $50.00**. To avoid missed appointments, we offer a confirmation call 2 days before scheduled appointments and a courtesy texts as well**.** ***If you are more than 10 minutes late, you will be asked to reschedule your appointment***.

DENTAL INSURANCE

It is the patient's responsibility to provide our office with correct and updated insurance information. We are happy to file the necessary claim forms to assist you in receiving the full benefit of your coverage, however, we cannot guarantee any estimated coverage; the insurance company policy is an agreement between you and the insurance company (**patients are ultimately responsible for all charges**). If your insurance carrier does not pay the balance in full, we will send you a statement for the remaining balance. Often, you will receive an Explanation of Benefits (EOB) from your insurance company showing what is paid and what your responsibility is.

PAYMENT OPTIONS

Payment is due at time of service. For your convenience, we have made an arrangement to accept payments by several major credit cards: Visa, American Express, Discover and Master Card. We also accept cash and money orders. We do not offer in house financing. We do accept Care Credit.

COLLECTIONS

After 60 days, all delinquent accounts will be referred to a collection agency. The patients or guarantors of the account will be responsible for all collection fees.

I understand and agree to these terms and conditions.

_____

(PLEASE SIGN HERE)

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have read your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient's Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

(Office Use Only)

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials: _____ Reason: _____

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Composite (White) Filling Consent

Under the provisions with most insurance companies, when a composite (white) filling is placed on a posterior (back) tooth, an alternate benefit of an amalgam (silver) filling is provided. I understand that there may be a balance on my account left if the insurance company downgrades my white filling to a silver filling.

My signature indicates my acknowledgement that I have read and agree to all of the above and consent to treatment.

Responsible Party Signature Relationship to Patient Date

General Treatment Consent

I consent to receive dental services provided by Dr. Zena Sadik-Yosif and her staff, including examination, dental prophylaxis (cleaning) and routine fillings. I understand that the initial visit may require radiographs to complete the examination, diagnosis and treatment plan. I understand I will be provided a treatment plan for necessary services; however, I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to my treating dentist to make any/all changes and additions as necessary. I further understand that clicking, popping, and pain in the jaw joint may occur as a normal part of treatment; however, should the discomfort become intolerable, I may be referred to a specialist for treatment, the cost of which is my responsibility.

Patient Signature _____ Date _____

Covid – 19 Consent

I _____, knowingly and willingly consent to have dental treatment completed during the COVID-19 (Coronavirus) pandemic.

_____(INITIALS)

- I understand COVID-19 (Coronavirus) has a long incubation period, approximately 2-14 days (potentially longer). Due to the long incubation period, carriers of the virus may show no symptoms and still be highly contagious. It is that ALL patients seen in the office during this time understand that DENTAL procedures create aerosols in the air, which is one form of COVID-19 (Coronavirus) transmission.

_____(INITIALS)

- I understand that due to the frequency of visits of other patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus by being in a dental office.

_____(INITIALS)

- I confirm that I am not presenting any following symptoms of COVID-19 listed below:
    - Fever
    - Shortness of breath
    - Dry Cough
    - Runny Nose
    - Sore Throat
    - Exposure to anyone else with a positive diagnosis and/or above symptoms