Apple Dental

Ahmed R. Megally Dental Corp.

Office Policies & Notice of Privacy Practice

1. Appointments cancelled **REQUIRE 24-HOUR** advance notice.
2. The first missed appointment will result in a $50 charge to your account. This is not billable to your insurance.
3. The **THIRD** missed appointment without notice will result in a dismissal from our office. **TREATMENT APPOINTMENTS WILL ONLY BE ALLOWED TO MISS OR RE-SCHEDULE TWICE.**
4. **Un- confirmed appointments may lead to a cancelled appointment.**
5. If you have a change of address, phone number, or insurance information, please notify us **IMMEDIATELY** so we can update the information in your file. If we do not have the correct information, YOU may be held responsible for payment of the entire account regardless of insurance coverage.
6. Any phone number, e-mail and address provided by patient/ parent/ guardian, will be used to contact you/ patient in any necessary way.
7. Please read and check your monthly statement carefully. If you do not receive your billing statements by the 15th of the month please call our office. No refunds or credits will be issued 90 days of pending or completed treatment.
8. **PAYMENT IS DUE AT THE TIME OF SERVICE**. Available methods of payment are Visa, MasterCard, Cash, Personal checks and American Express. We charge a 4% processing fee for all debit/ credit card transactions. If you have dental insurance we will bill them for you. If for any reason your insurance denies a payment for any provided services, the balance will be your responsibility. If your insurance requires a co-payment, it will be due at the time of service.
9. The following policy will be strictly enforced: Any returned check will incur a $25 service charge and we will no longer accept check payments. Accounts not paid within 60 days are considered past due and may result in referring the account to a collection agency and possibly filing a lawsuit to recover any amount owed. You agree to pay a collection fee and interest charge at an annual rate of 10% of any unpaid balance, beginning 30 days after the initial date of service. If legal action is required, you agree to pay all reasonable attorney fees and court costs in addition to any outstanding balance, collection fees and interest.
10. A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void & unenforceable.
11. We do reserve the right to refuse service to anyone, but we will not discriminate based upon gender or race. Inappropriate language or behavior **will lead to a dismissal from our office.**
12. I have seen the Notice of Privacy Practice, and upon request we can give you a copy. I have seen the Dental Material Fact Sheet. I understand and agree that there are security cameras on the premises for safety and legal purposes. I am aware that Ahmed R. Megally Dental Corp will be billing my insurance and receiving payment.

I have read the above and agree to abide by the policies set forth by this office.

Signature of Self, Parent, or Guardian

Date

WELCOME TO OUR PRACTICE

Patient Information (confidential)

Name: _____ DOB: _____ SS # (adults only): _____

Address: _____ City: _____ State: _____ Zip: _____

How would you like to be contacted? Cell: _____ Home: _____

Email: _____ Gender: Male ☐ Female ☐

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Long term Partner ☐ Widowed ☐ Separated

Employer name: _____ Phone #: _____

Spouse or Partner Name: _____ Cell #: _____

Full Time Student? YES NO Name of School: _____

Person to contact in case of Emergency: _____ Phone #: _____

Whom may we thank for referring you? _____

IF PATIENT IS A MINOR – COMPLETE THIS SECTION

Mother/ Guardian: _____ Father/ Guardian: _____

Date of Birth: _____ Date of Birth: _____

Phone/ Cell #: _____ Phone/ Cell #: _____

Employer Name: _____ Employer Name: _____

Employer Phone #: _____ Employer Phone #: _____

INSURANCE INFORMATION

Name of insured: _____ Relationship to Patient: _____

Birthdate: _____ SSN/ ID #: _____

Insurance Company: _____ Group#: _____

Secondary INS **(if applicable)**

Name of insured: _____ Relationship to Patient: _____

Birthdate: _____ SSN/ ID #: _____

Insurance Company: _____ Group#: _____

I hereby authorize payment of insurance benefits directly to Apple Dental otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may **pay less** than the actual bill for services. **I understand I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in party by my dental care payer.

I ATTEST TO THE ACCUARACY OF THE INFORMATION ON THIS PAGE

_____ _____

Signature of Patient/ Parent/ Guardian Date

Patient Medical History

Patient Name: _____ Previous Dentist: _____

Allergies (seasonal).....	YES	NO
Anemia.....	YES	NO
Arthritis.....	YES	NO
Asthma.....	YES	NO
Cancer.....	YES	NO
Cardiac Pacemaker	YES	NO
Chemotherapy.....	YES	NO
Diabetes.....	YES	NO
Emphysema	YES	NO
Epilepsy/ Convulsions.....	YES	NO
Fainting.....	YES	NO
Glaucoma.....	YES	NO
High Cholesterol.....	YES	NO
Heart Attack.....	YES	NO
Heart Condition.....	YES	NO
Heart murmur.....	YES	NO
Hemophilia.....	YES	NO
Hepatitis A, B, C (other) please circle one..	YES	NO
High Blood Pressure.....	YES	NO
HIV/ AIDS	YES	NO

Are you currently taking any medications? YES NO
If YES, Please list: _____
_____

Are you under medical treatment now?... YES NO

Have you been hospitalized for ANY ..... YES NO
surgical operations or serious illness
within the last 5 years? (If **YES**, please specify)
_____

Have you ever taken Fen-Phen/ Redux?....YES NO
Have you ever taken Fosamax, Boniva,
Actonel, or any other Cancer medications
Containing Bisphosphonates? ..... YES NO

Have you been advised by your Medical Doctor that you need to pre-medicate Before ANY dental treatment? ..... YES NO

Joint/Artificial replacement.....	YES	NO
Kidney Disease.....	YES	NO
Liver Disease.....	YES	NO
Low Blood Pressure.....	YES	NO
Mitral Valve Prolapse.....	YES	NO
Osteoporosis.....	YES	NO
Psychiatric Problems/ History.....	YES	NO
Radiation Therapy.....	YES	NO
Respiratory Problems.....YES		NO
Rheumatic Fever.....	YES	NO
Seizures.....	YES	NO
Shingles	YES	NO
Sickle Cell Disease.....	YES	NO
Stomach Troubles/ Ulcer.....	YES	NO
Stroke.....	YES	NO
Thyroid Problem.....	YES	NO
Tuberculosis	YES	NO
ADHD or Autism (circle which applies)...	YES	NO
Herpes.....	YES	NO

Other Condition(s) not listed: _____
_____

Are you allergic to or have you had any reactions to the following?

Anesthetics (example: Novocain).....	YES	NO
Metals (example: nickel, mercury, jewelry)...	YES	NO
Latex Rubber.....	YES	NO
Codeine.....	YES	NO
Aspirin.....	YES	NO
Erythromycin	YES	NO
Sulfa	YES	NO
Penicillin.....	YES	NO

Other (please list)_____

Do you use Tobacco?	YES	NO
Do you have history of drug/ alcohol Or controlled substance abuse? ...	YES	NO
Do you use controlled substances?....	YES	NO

WOMEN ONLY

Are you pregnant or think you may be? YES NO
Are you nursing (breast feeding)?..... YES NO

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 (patient's) health. It is my responsibility to inform the dental office of any changes in my medical status. I authorize the dentist to perform diagnostic/preventative procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning mine (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering a claim for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment to another to another dentist.

I ATTEST TO THE ACCURACY OF THE INFORMATION IN THIS PAGE.

Signature of Patient/ Parent/ Guardian _____ Date _____