



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

### Patient Information

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

SSN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State/Zip \_\_\_\_\_

Phone \_\_\_\_\_  Home  Work  Cell

Phone \_\_\_\_\_  Home  Work  Cell

E-mail \_\_\_\_\_

Sex  Male  Female    Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married     Widowed     Single     Minor

Separated     Divorced     Partnered for \_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_

SSN \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you?  
\_\_\_\_\_

### Dental Insurance

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by an additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

2<sup>nd</sup> Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_

Policyholder's Full Name \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Dr. Shohreh Sharif all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Shohreh Sharif & Associates may use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

Print Patient Name

### Emergency Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_  Home  Work  Cell    Phone \_\_\_\_\_  Home  Work  Cell

## Dental History

Reason for today's visit \_\_\_\_\_

Blister on lips or mouth  Yes  No

Burning sensation on tongue  Yes  No

Chew on one side of mouth  Yes  No

Cigarette, pipe, cigar smoking  Yes  No

Clicking or popping jaw  Yes  No

Dry mouth  Yes  No

Fingernail biting  Yes  No

Food collection between teeth  Yes  No

Foreign objects  Yes  No

Grinding teeth  Yes  No

Gums swollen or tender  Yes  No

Jaw pain or tiredness  Yes  No

Lip or cheek biting  Yes  No

Loose teeth or broken fillings  Yes  No

Mouth breathing  Yes  No

Mouth pain, brushing  Yes  No

Orthodontic treatment  Yes  No

Pain around ear  Yes  No

Periodontal treatment  Yes  No

Sensitivity to cold  Yes  No

Sensitivity to heat  Yes  No

Sensitivity to sweets  Yes  No

Sensitivity when biting  Yes  No

Sores or growths in mouth  Yes  No

Former Dentist \_\_\_\_\_

City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_

Date of last dental X-rays \_\_\_\_\_

**Place a mark on "yes" or "no" to indicate if you have had any of the following:**

Bad Breath  Yes  No

Bleeding gums  Yes  No

How often do you floss? \_\_\_\_\_

How often do you brush? \_\_\_\_\_

## Health History

Physician's Name \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

Other Healthcare Provider/Specialist being seen:

Name \_\_\_\_\_ City/State \_\_\_\_\_ Reason \_\_\_\_\_

### Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting of dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma, Hayfever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsilitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wear contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Women:</b> Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		On birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## Medications

List any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

## Allergies

Aspirin

Barbiturates (Sleeping pills)

Codeine

Iodine

Local Anesthetic

Penicillin

Sulfa

Other \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

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## NOTICE OF PRIVACY PRACTICES

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**This notice describes how health information about you may be used and disclosed and how you can get access to this information.**

**Please review it carefully. The privacy of your health information is important to us.**

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/23/2018, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.35 for each page, \$40.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of the Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.



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## FINANCIAL POLICY

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It is the **patient's** responsibility to be well informed of their insurance coverage. This includes but is not limited to maximums, deductibles, coinsurance, frequency, and for services covered. For preventive and diagnostic services performed every six months, our office provides a periodic exam, prophylaxis, and x-rays as needed. Our office is unable to recall each and every patient(s) individual insurance coverage. Therefore, once treatment is rendered the patient is responsible for payment in full.

Every patient is given a treatment plan if there are any procedures recommended in addition to the regular six month re-care. The treatment plans are only **estimated** fees. As a courtesy, we will file the claim with your dental insurance company. However, exact co-pay/co-insurance amounts are unknown until treatment is completed and the claims are submitted, processed, and received by the insurance company. **The patient is responsible for their co-pay portion on the day services are rendered.** For all hospital cases, please refer to your hospital instructions sheet.

In order to be respectful of the dental needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. **To avoid a cancellation fee of \$75.00, a 48-hour (business day) notice is required for any rescheduling or canceling of an office appointment. A 72 hour (business day) notice (from the time of your appointment) is required for rescheduling or canceling appointments made on regular holiday.** You may be asked to reschedule your appointment if you arrive 15 minutes or later. For all hospital cases, please refer to your hospital instructions sheet.

**Disclaimer:** Payment is due in full at the time services are rendered for all none insured patient(s). Cash, check, and Visa/MasterCard are accepted. The patient is ultimately responsible for any and all fees incurred. If dental insurance is filed, the estimated co-pay portion is due in full for treatment performed at the time services are rendered. The patient is further responsible for any amount discounted or disallowed by the insurance plan, except in the case where the amount is a contractual discount. If the insurance does not remit payment within 60 days, the full balance becomes the obligation of the patient, and it is then their burden to collect from the insurance carrier. Accounts 60 days overdue are subject to a monthly late fee. If an account should ever require collection action, the parent/guardian will be obligated to pay any and all collection, attorney, and legal fees.

**Patient Consent:** I understand the information that I have given is true and correct to the best of my knowledge. It will be my responsibility to notify the office of any changes in my medical status, dental insurance, and address or phone numbers. I also authorize the Doctor and Staff to perform the necessary dental services that I may need.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_



Greater Washington  
**DENTISTRY**  
PEDIATRICS | ORTHODONTICS | GENERAL  
Shohreh Sharif, D.D.S. & Associates P.C.

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**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

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I, \_\_\_\_\_, have received a copy of this office's Notice of Private Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**ACKNOWLEDGEMENT OF RECEIPT OF  
FINANCIAL POLICY**

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I, \_\_\_\_\_, have received a copy of this office's Financial Policies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date