saad ORAL HEALTH & BEAUTY

WELCOME!

Thank you for choosing Saad Dental Group to help care for your oral health. We all look forward to getting to know you better.

In order for us to evaluate and treat you with the most optimal care, it is very important for you to retrieve your most recent records (including all x-rays) from your previous dentist prior to your appointment with us.

To make this process easier, please provide us with your previous dentist's contact information and we will request the records on your behalf (after the transfer papers are signed.) If you do not have access to your prior records, we will need to take the necessary x-rays in order to do a comprehensive examination. You will be responsible for the cost of the x-rays if your insurance company will not pay for them.

Please review the remaining items in this packet, fill out the paperwork, and return them during your first visit.

It is our pleasure to welcome you as a new patient to our practice. If you have any questions or concerns, feel free to call us any time.

Ali Y. Saad, DMD
Mohamed Y. Saad, DDS
Roua Al-Rawi, DDS
Linda Murad-Ajluni, DDS

837 Forest Avenue
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248 646-3515 office
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PATIENT HEALTH AND HISTORY

INFORMATION ABOUT THE PATIENT

Name: _____ Home Phone #: _____

Address: _____ Cell Phone #: _____
street

_____ Social Security #: _____
city state zip code

Birthdate: _____ Sex: _____ Marital Status: _____

Employer: _____ Work Phone #: _____

Employer's Address: _____ E-mail address: _____
street

_____ Who may we thank for referring you: _____
city state zip code

SPOUSE INFORMATION

Spouse's Name: _____ Spouse's Employer: _____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____

PERSON RESPONSIBLE FOR ACCOUNT OTHER THAN YOURSELF

Name: _____ Social Security #: _____

Address: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____

Driver's License #: _____ Work Phone #: _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Co. Name: _____ Insurance Co Phone #: _____

Insured's Name: _____ Relationship: _____

Insured's Soc. Sec. # _____ Group/ID #: _____

Insured's Birthdate: _____ Insured's Employer: _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insured's Name: _____ Relationship: _____

Insured's Soc. Sec. #: _____ Group/ID #: _____

Insured's Birthdate: _____ Insured's Employer: _____

CONTINUES ON OTHER SIDE

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PATIENT HEALTH AND HISTORY

DENTAL HISTORY

Do you require antibiotics (PRE-MED) before dental treatment?: _____Have you ever had gum disease?: _____

Do you now (or have ever) experienced pain/discomfort in your jaw joint TMJ/TMD?: _____Do your gums ever bleed? _____

Previous/Present Dentist: _____Last Dental Visit Date:_____

(circle one)

MEDICAL HISTORY

Your physician's name: _____ Physician's phone #:_____

Do you take a blood thinner or blood pressure medications?: _____

Your current medications:_____

Are you taking them as directed? _____If *No,* please explain: _____

Are you taking any non-prescription or herbal medications or supplements?: _____

Are you allergic to any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Aspirin (AA)	___	___	Dental Anesthetics (DE)	___	___	Latex (LA)	___	___	Sulfa Drugs (SU)
___	___	Barbiturates (BA)	___	___	Erythromycin (EY)	___	___	Penicillin (AP)	___	___	Tetracycline (TE)
___	___	Codeine (AC)	___	___	Jewelry/Metals (3M)	___	___	Sedatives (SP)	___	___	Iodine (IO)

List any additional drugs / materials that cause allergic reactions: _____

Yes	No		Yes	No		Yes	No	
___	___	Abnormal Bleeding (AB)	___	___	Eating Disorders (ED)	___	___	Nervous Problems (NE)
___	___	Acid Reflux (AF)	___	___	Epilepsy (EP)	___	___	Oral Surgery (OS)
___	___	AIDS / HIV (A)	___	___	Fainting Spells (FA)	___	___	Pacemaker (PA)
___	___	Alcohol Addiction (AU)	___	___	Freq. Headaches/ Migraine (HC)	___	___	Periodontal Surgery (PR)
___	___	Arthritis (AR)	___	___	Heart Attack (HA)	___	___	Prosthetic Joints (PJ)
___	___	Artificial Heart Valves (AH)	___	___	Heart Murmur (HM)	___	___	Radiation Treatments /Chemo (CM)
___	___	Asthma (AS)	___	___	Heart Surgery (HS)	___	___	Rheumatic Fever (RH)
___	___	Blood Disease (BD)	___	___	Hemophilia (HO)	___	___	Scarlet Fever (SF)
___	___	Blood Transfusions (BT)	___	___	Hepatitis *(date*_____	___	___	Sinus Problems (SI)
___	___	Cancer (CA)	___	___	High Blood Pressure (HB)	___	___	Smoke or Use Tobacco (SM)
___	___	Chest Pains (CP)	___	___	Implants (any type)	___	___	Stroke (ST)
___	___	Circulatory Problems (CR)	___	___	Kidney Disorders (KT)	___	___	Thyroid Problem (TH) (TL)
___	___	Complication from Dental Surgery (CD)	___	___	Liver Disease (LD)	___	___	Tuberculosis (TB)
___	___	Convulsions or Seizures (SE)	___	___	Low Blood Pressure (LB)	___	___	Ulcers (UL)
___	___	Diabetes (DI)	___	___	Mitral Valve Prolapse (MP)	___	___	Venereal Disease (VD)
___	___	Drug Abuse (DA)						

Please explain any hospitalizations, surgeries, or serious medical condition: _____

For women:

Are you taking birth control pills? _____ Are you pregnant? _____ Week # _____ Are you nursing? _____

I affirm that the information I have given is correct to the best of my knowledge.
It is my responsibility to inform this office of any changes in my medical status.
I authorize the dental staff to perform the necessary dental service I may need.
I understand that I am responsible for payment of all services rendered, but as a service to me, this office will submit dental claims. I assign to Saad Dental Group, all insurance benefits, otherwise payable to me. I authorize them to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature (Patient/Legal Guardian): _____

Payment is due at time of service:
Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

MEDICAL HISTORY UPDATE

B/P Pulse Date Staff

_____

_____

_____

_____

_____

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CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Saad Dental Group, to take photographs, and/or videos of my face, jaws, and teeth, before, during, and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, and professional publications such as journals or books
- Marketing material, including websites, printed materials, and patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

____ Check here if you **do not** want your full face shot used for any of the above purposes.

Signature (Patient/Legal Guardian): _____

Date: _____

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Financial Policy

Our office has always been happy to work with patients regardless of dental coverages. We think insurance is a great incentive to maintain a vital level of dental health. But it is a rare, very rare dental plan that covers 100% of our fees.

Here is why:
The fees we charge for dental services are the same for every patient, insured or not. A given insurance policy, however, is based on a fixed fee schedule- "what your insurance company or employer will pay based on your individual policy."

Saad Dental is not a provider for every insurance company. Your dental insurance is your financial responsibility. Please realize that it is a courtesy to you that we verify dental benefits and bill your insurance. We also as a courtesy provide an estimate of co-pay however, regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you the patient, parent, or guardian, are responsible for the total cost of your dental treatment. You are responsible at the time of your appointment, for any deductible and co-payment not covered by your insurance carrier. Once our office has received payment from the insurance company, if any balance is remaining, you will be billed within 30 days.

You may make any payment using cash, check, credit card, Care Credit, or Lending Point. Care Credit and Lending Point are outside finance companies we offer that will allow you to take advantage of the interest free financing.

I understand and acknowledge that I am financially responsible for the services provided to myself, another family member, regardless of insurance coverage.

_____ _____

Signature of Responsible Party Date

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") require that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to of consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____

Patient/Parent/Guardian Signature **Patient/Parent/Guardian Name (Please print)**

Date: _____

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient from signing the Acknowledgement.

_____ _____

Office Personnel Signature **Office Personnel (Print Name)**

Date:_____

_____ Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____

Patient/Parent/Guardian Signature **Patient/Parent/Guardian (Please print) .**

Date: _____