SAID DENTAL
Skilled Attentive Innovative Dentistry

Welcome to Our Practice!

We are committed to providing exceptional dental care to our patients in a compassionate, professional environment. The following information is provided to introduce you to our practice philosophy and policies.

Appointments and Cancellations

Appointments are scheduled so we can provide the most efficient care in a relaxed setting. We make every effort to honor time commitments and we appreciate patients extending us the same courtesy. Patients are reminded of their appointments 2 days in advance phone. Patients are kindly asked to confirm their appointment at least 2 business days prior to their appointment. Patients who do not provide two business days notice of cancellation may be charged a fee.

New Patient Appointments

We reserve 90 minutes for each new adult patient visit and 60 minutes for each new child visit. This allows time for us to listen to patient concerns and to properly diagnose and develop appropriate treatment plans.

Continuing Care

Our practice is focused on prevention and maintaining optimum oral health. We recommend comprehensive treatment and continuing care on an appropriate recall schedule.

Urgent Care After Hours

We accommodate patients of record who experience dental emergencies after hours. A patient of record is one who has been seen and treated in the office during the past 18 months. If you are a patient of record and have a dental emergency, you can call the office for information on how to contact us.

Children and Adolescents

We are happy to start seeing children at the age of One. Parents are welcome to accompany their children in the operatories. We require that parents remain in the office with children under the age of 18 for the entire appointment. Failure to comply may result in the appointment being rescheduled.

Payments and Insurance

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. As a result, we offer several payment options, including cash, check, credit card, and third party financing. For patients with dental insurance, we will file the appropriate claim forms.

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Patient Information

Name: _____ Preferred Name: _____

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

Home #: _____ Work #: _____ Mobile #: _____

What is the best way to communicate with you? Home Phone / Mobile Phone/ Work Phone

Best time to reach you:_____

Email: _____

Sex: M / F Birth Date: ___ /___ /_____ SS#:_____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

In case of an emergency who should be notified?

Name:_____Phone #:_____Relationship:_____

How did you first hear about our office? (circle one):

☐ Another Patient ☐ Another Dental Office ☐ Online Search
☐ Facebook ☐ Work ☐ Insurance Website ☐ Other_____

We like to reward our patients who refer their family, friends, and co-workers. Which reward would you prefer?

Starbucks Gift Card iTunes Gift Card Credit to Account

Whom may we thank for referring you to our practice?_____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State: _____Zip: _____

Home #: _____Work #: _____ Mobile #: _____

Email: _____

Birth Date: ___ /___ /_____ SS#:_____

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Insurance Information (Primary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Insurance Information (Secondary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #:_____

Claims Address _____

City, State, Zip _____

Group #: _____ ID #: _____

Employment Information

Employer Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

Cancellations and Missed Appointments

We require 2 business days notice of a cancellation. Patients who do not provide 2 business days notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. Patients who fail to present for a second appointment may be charged a fee or dismissed from the practice. After the first missed appointment, a letter will be mailed reiterating our policy and reminding the patient of the risk of dismissal should another appointment be missed.

I have read the Cancellation and Missed Appointment Policy. I understand and agree to this Policy.

Patient Signature_____Date_____

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Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No
_____
3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? _____
Aredia	Reclast	Zometa	When did you stop? _____

8. Please list other medications you are taking:
_____
_____

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A	Yes No	Hay Fever	Yes No
Psychiatric Treatment	Yes No	Hepatitis B	Yes No	Tobacco Products	Yes No

Sickle Cell Disease	Yes	No	Hepatits C or D	Yes	No	Bruise Easily	Yes	No
Sinus Trouble	Yes	No	Pacemaker	Yes	No	Jaundice	Yes	No
Artificial Joints	Yes	No	Night Sweats	Yes	No	Kidney Trouble	Yes	No
Thyroid Disease	Yes	No	Stroke	Yes	No	Diabetes	Yes	No
Anemia	Yes	No	Drug Addiction	Yes	No	Chemotherapy	Yes	No
Blood Transfusion	Yes	No	Cold Sores	Yes	No	Cancer	Yes	No
Mitral Valve Prolapse (MVP)	Yes	No	Radiation Therapy	Yes	No	Transplant	Yes	No

Dental History

1. Date of last dental exam:_____ Date of last dental x-rays: _____
2. Previous dentist's name / location:_____
3. Are you having tooth or gum pain at this time? ☐ Yes ☐ No
4. Do you feel nervous about having dental treatment? ☐ Yes ☐ No
5. Have you ever had a bad experience in a dental office? ☐ Yes ☐ No
6. Do your gums bleed when brushing / flossing? ☐ Yes ☐ No
7. Have you ever seen a periodontist? ☐ Yes ☐ No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? ☐ Yes ☐ No
9. On a scale 1-10 (10 being Highest), How important is it to you to keep your teeth? _____
10. Would you be interested in discussing ways to improve your smile? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking in jaw joint	☐ Yes ☐ No	Sensitivity to: ☐ Hot	☐ Cold	☐ Sweets ☐ Biting
Pain in or around your ears	☐ Yes ☐ No	☐ Swelling	☐ Bleeding Gums	
Difficulty opening or closing	☐ Yes ☐ No	☐ Bad Taste	☐ Bad Breath	
Difficulty chewing	☐ Yes ☐ No	☐ Food Catching	☐ Tooth Pain	
History of trauma to jaw or face	☐ Yes ☐ No	☐ Clenching	☐ Grinding	
Diagnosis of TMJ/TMD	☐ Yes ☐ No	☐ Other: _____		

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature: _____ Date_____

Doctor's Signature_____

Doctor's Notes:

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Financial Guidelines

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. Therefore, we are pleased to offer several payment options. Please read the following carefully. Our financial coordinator will answer any questions you may have, and assist you in selecting the appropriate financial plan for your needs.

For your convenience, we offer the following financial options:

1. In addition to personal checks and cash, we also accept payment through MasterCard/Visa, American Express, and Discover.

2. CareCredit Card
CareCredit is a healthcare credit card designed for your health and wellness needs for you and your entire family. To learn more about this financial option please contact our front office for more information.

3. Dental Insurance

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. However, please keep the following in mind:

- Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage, and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.

- Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.

- Our participation in a Preferred Provider Organization (PPO) is a contract between this office and the organization to provide dental services for the negotiated network fee schedule. Individual coverage and benefits will vary within the organization and are dependent on the contract between you, your employer and the insurance company. While we guarantee our fees will not exceed the network fee schedule, we cannot be responsible for variances in coverage and benefits within the PPO.

- If your coverage changes for any reason, please notify the office immediately

By signing this form, you have read and understand our policy. Any denials or insurance payments less than estimated will be your responsibility. Payment will be due upon our billing cycle. All estimated out of pocket fees and deductibles are due the day of treatment. Ask our office regarding our financial options before your visit, or if you have any questions regarding your insurance and our policy.

I have read the Financial Policy. I understand and agree to this Policy.

_____ _____

Signature of Patient or Responsible Party Date

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____

Signature Date

----------FOR OFFICE USE ONLY----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)

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Authorization for Release of Information to Family and/or Friends

Name of Patient_____ Date of Birth_____

Dr. Bassem Said is authorized to discuss my dental care and may release my confidential health information to the following:

_____ _____
Name Relationship

_____ _____
Name Relationship

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Dr. Bassem Said, 4565 Dressler Rd. NW Suite 102, Canton, OH 44718.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effective until revoked by the patient or representative signing the authorization.

_____ Date_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)