Sam Daoud, DDS, LLC — Child Registration

215 Miller Rd. Ste. #3
Avon Lake, OH 44012
(440) 933-9533

3708 Columbus Ave. Units 10-11
Sandusky, OH 44870
(440) 625-6331

These questions are of great value in understanding, diagnosing and treating your child.

Child's Name _____ Your child likes to be called_____

Age____ Date of Birth___-___-___ Sex ( )F ( )M Home Phone_____-_____-_____

Address_____ City_____ State_____ Zip Code_____

Father_____ Employer_____ Work Phone_____-_____-_____

Address_____ City_____ State_____ Zip Code_____

Dental Insurance ( )Y ( )N Ins. Name_____ Date of Birth___-___-___ SSN___-___-___

Mother_____ Employer_____ Work Phone_____-_____-_____

Address_____ City_____ State_____ Zip Code_____

Mother Cell phone_____-_____-_____ Father Cell Phone_____-_____-_____

Dental Insurance ( )Y ( )N Ins. Name_____ Date of Birth___-___-___ SSN___-___-___

Policy Holders Marital Status_____ # of Children_____ Ages_____

By whom were you referred to this office?_____

Close relative name_____ Address_____ Phone #_____

Physician or Pediatrician of child_____ Address_____ Phone#_____

MEDICAL HISTORY

Is your child in good health?…….....( )Yes ( )No

Has your child had regular medical checkups ?…….....( )Yes ( )No

Has your child ever been hospitalized?……..... ( )Yes ( )No

If so, for what?_____

Has your child ever been treated in an emergency room?……( )Yes ( )No

Do you consider you child to be ___Advanced in the learning process

___Progressing normally ___A slow learner

Has your child been immunized for:

Deptheria, Whooping cough (pertussis) and Tetanus…….( )Yes ( )No

Polio……..... ( )Yes ( )No

Measles and German Measles (rubella)…….....( )Yes ( )No

Has your child had a DPT and Polio Booster?…….....( )Yes ( )No

At 1-2 years……..... ( )Yes ( )No

At 3-4 years……..... ( )Yes ( )No

Diptheria and Tetanus (adult type) every 10 years thereafter……... ( )Yes ( )No

Has you child ever been allergic to anything ?……..... ( )Yes ( )No
If yes, what_____

Is your child taking any medications now?……..... ( )Yes ( )No
If yes, what kind_____

Has your child ever had an unfavorable reaction to any medicine?…….....( )Yes ( )No
If yes, what_____

Has your child ever tested positive for the H.I.V. virus?……..... ( )Yes ( )No
If yes, explain_____

Does your child have, or have they had any emotional, mental or nervous disorders?……( )Yes ( )No

Has your child been put to sleep for medical or dental treatment?……..... ( )Yes ( )No

Place a check in the proper bracket if your child now has problems with any of the following:

( )Heart	( )Epilepsy	( )Heart Murmur	( )Rheumatic Fever
( )Kidney	( )Diabetes	( )Speech	( )Tuberculosis
( )Fever	( )Asthma	( )Seizures	( )Cerebral Palsy
( )Hay Fever	( )Cleft Palate	( )School	( )Artificial Joints
( )H.I.V. Positive	( )AIDS	( )Artificial Heart Valves	( )Excessive bleeding when cut

DENTAL HISTORY

Is this you child's first visit to the dentist?…….....( )Yes ( )No
If no, explain_____

Does your child take fluoride or vitamins with fluoride?…….....( )Yes ( )No

Has your child inherited any family dental characteristics?_____

Please check in the proper bracket if your child has or had any of the following dental problems:

( )Cavities	( )Teeth Bumped
( )Toothache	( )Crooked teeth
( )Teeth sensitive to sweets	( )Color of teeth
( )Teeth sensitive to hot or cold	

Have there been any other dental problems…….....( )Yes ( )No
If so, what_____

Have there been any injuries to your child's teeth?…….....( )Yes ( )No

Does your child have any oral habits? (Thumb sucking, lip biting, finger sucking)…… ( )Yes ( )No

If your child was bottle fed, at what age did your child give it up completely?……( )Yes ( )No

Please check reason for visiting our office:

( )Cavities	( )Teeth Bumped	( )Toothache	( )Teeth sensitive to sweets
( )Crooked Teeth	( )Color of teeth	( )Teeth sensitive to hot or cold	

Have there been any other dental problems?…….....( )Yes ( )No
If so, what_____

I have read my MEDICAL HISTORY dated_____ and confirm that it adequately states past and present conditions.

SIGNATURE:_____ DATE:_____

Dr. S. Daoud_____ DATE:_____

Sam Daoud, DDS, LLC — Permission to Administer Treatment

215 Miller Rd. Ste. #3
Avon Lake, OH 44012
(440) 933-9533

3708 Columbus Ave. Units 10-11
Sandusky, OH 44870
(440) 625-6331

1. TREATMENT TO BE DONE

I understand that I am to have dental work done as detailed in the treatment plan.

Initials:_____

2. DRUGS AND MEDICATION

I understand that antibiotics, analgesics, and other medications can cause allergic reactions such as redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the dentist of any known allergies to medication. Women are advised that antibiotics may interfere with the effectiveness of birth control pills. Other means of contraception are recommended while taking antibiotics.

Initials:_____

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedure because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make all/any changes and additions as necessary.

Initials:_____

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.), and I authorize the Dentist to remove the following teeth_____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection; if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, excessive bleeding, damage to adjacent teeth, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parasthesia) that can last for an indefinite period of time, or fractured jaw. I understand that I may need further treatment by a specialist if complications arise. The cost; which is my responsibility.

Initials:_____

5. CROWNS AND VENEERS

Treatment involves covering the tooth completely with a cap (crown) or covering the front surface of the tooth with a tooth colored bonded porcelain laminate called veneer. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may follow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

Initials:_____

6. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally the canal filling material may extend through the tooth root tip, which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fractures are one of the main reasons why root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. It also prevents a root canal from being reinfected. I understand that endodontics files and reamers are very fine instruments and stresses in their manufacture can cause them to separate during use. I understand the occasionally referral to a root canal specialist (endodontist) may be necessary to retreat difficult root canals or perform additional surgical procedures that may be necessary following root canal therapy (apicoectomy). Specialty fees are the patients responsibility. I understand the tooth may be lost in spite of all efforts to save it.

Initials:_____

7. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation and that it can lead to the loss of my teeth and/or supporting bone. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that periodontal disease may have a future adverse affect on the long term success of dental restorative work.

Initials:_____

8. FILLINGS

I understand that more extensive restorative than originally diagnosed may be required due to additional decay found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown or both. I understand that sensitivity is a common after effect of a newly placed filling.

Initials:_____

9. ADVANCE/ AMALGAM BOND

Advance/amalgam bond has been offered to me as optional treatment to reduce sensitivity and strengthen fillings or crown build-ups.

Initials:_____

10. DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures(including shape, fit, size, placement, and color) will be the “teeth in wax” try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate denture may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

Initials:_____

11. BLEACHING

Bleaching is a procedure done either in office (1 hour) or with take home trays (2 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on dental shade guide). Coffee, tea, and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which will subside when treatment is discontinued. The doctor may prescribe fluoride treatment for rare cases of persistent sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

Initials:_____

12. CHILDREN’S DENTISTRY

Children who are difficult to manage or have extensive restoration needs may need to be referred to a children’s dental specialist (pedodontist). Our main concern is to make the dental treatment experience as pleasant as possible for our child. We will not force your child to have treatment done. This can cause psychological trauma.

Initials:_____

13. IMPLANTS

Implants restorative procedures can be complex and may require multiple appointments to complete. Implant success rate is approximately 95%. Proper maintenance of implant restorations is critical to their long term success. Implants can fail due to medical complications such as diabetes, effects of smoking gum disease, or grinding of teeth.

Initials:_____

I understand that dentistry is not exact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to proposed treatment.

X_____ X_____

Signature of Patient/Parent/Guardian Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 you health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect **04-14-03**, 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 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 change. Before we make a significant change in our privacy practices, we will change this Notice, please contact us using the information listed at the end of the Notice.

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 you r health information to a physician or other healthcare provider providing treatment to you.

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

Healthcare Operations: We may use and disclose you 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 a written authorization to use your health information or to disclose it to anyone for 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 authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose you health information for any reason except those describe in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights sections 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 of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on the 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 communication without your written authorization.

Required by Law: We may use or disclose your health information when we are requires 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 and 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 officials having lawful custody or 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).

PATIENTS 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 the 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 **$.15** for each page, **$15.00** 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 alternative 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 this 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 you 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 request.

Restrictions: 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 alternate locations. (You must make your own 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 Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

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 communication 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 heath information. We will not retaliate in any way if you chooses to file a complaint with us or with the U.S. Department of Health and Human Services.

Sam Daoud, DDS, LLC

Sam Daoud, DDS, LLC

215 Miller Rd. Ste. #3
Avon Lake, OH 44012
(440) 933-9533

3708 Columbus Ave. Units 10-11
Sandusky, OH 44870
(440) 625-6331

ACKNOWLEDGEMENT OF POSTED NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement**

I, _____, have seen a copy of this offices Notice of Privacy Practices.

_____

Please Print Name

_____

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:

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

_____

_____

_____

Financial Policy

We ask all patients to read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the dentist. Payment of services are due at the time services are rendered. We accept cash, checks, visa and master card.

We may accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.
2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. I understand that employees of Sam Daoud, DDS, LLC are NOT representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company.
5. If your insurance company does not pay your claim within 30 days, it is your responsibly to contact your insurer to expedite payment. If your insurance does not pay, you are responsible for your payment.
6. If your insurance company does not pay within 45 days we may require you to pay the balance.
7. I authorize payment from my insurance carrier be made directly to the dentist.
8. I authorize this office to release necessary medical or dental information.

FIXED OR REMOVABLE PROSTHETICS, such as dentures, crowns, bridges or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services, is, therefore, considered to be due and payable when the initial impression is made. We accept insurance for payment for the covered portion, however, you must pay your portion at the time services are rendered. PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE YOUR COMFORT, AND PRPOER FIT. If you fail to have your prosthetics permanently seated within 60 days from the date of impression, a second impression must be made, you will be charged an additional amount. ALL X-RAYS TAKEN ARE A PART OF OUR PERMANENT RECORDS. WE WILL GLADLY MAKE YOU A DUPLICATE OF YOUR X-RAYS. WE DO REQUIRE A 5 DAY NOTICE. YOU ARE ALSO REQUIRED TO SIGN A RELEASE FORM.

Again we thank you for choosing Dr. Daoud as your dental care provider.
We appreciate your trust in us and the opportunity to serve you.

Patient or Guardian Signature_____ Date_____