U Sparkle Dental, P.A.

Dr. Kamila Husain D.D.S., & Associates 1013 Dairy Ashford Rd. Houston, TX 77079 | Tel 713-800-4200 | Fax 832-770-9366 smile@usparkledental.com | www.usparkledental.com

Patient Information

We are pleased to welcome you to our practice! To further assist your dental needs, please fill out the following form completely. If you have any questions we will be glad to help. We look forward to working with you in maintaining your dental health.

Patient Information

Date_____

Name_____ SSN_____

Phone (___) _____ Alt. Phone (___) _____

Address_____ Email_____

City_____ State_____ Zip_____

Sex: Male ☐ Female ☐ Birthdate_____

In case of an emergency, who should we notify? _____

Whom may we thank for referring you? _____

Name of Previous Dentist _____

Date of previous dental visit _____

Name of your Primary Care Provider _____

Date of last visit with your primary care provider _____

Primary Insurance

Main Subscriber on Account _____ Birthdate _____

Relationship to Patient _____ SSN _____

Address (If different from patient's) _____

City _____ State _____ Sip _____

Main Subscriber's Employer _____

Insurance Company Name _____

Subscriber# _____ Group# _____

Insurance Company's Contact Number _____

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Dental Health History

Do you have, or have you had any of the following? (check all that apply)

- ☐ Apprehension about dental treatment
- ☐ Problems with previous dental treatment
- ☐ Gag easily
- ☐ Wear dentures
- ☐ Food catches between your teeth
- ☐ Difficulty chewing your food
- ☐ Chew on only one side of your mouth
- ☐ Avoid brushing any part of your mouth because of pain
- ☐ Gums bleed easily
- ☐ Gums bleed when flossing
- ☐ Gums feel swollen or tender
- ☐ Notice slow-healing sores in or around your mouth
- ☐ Feel twinges of pain when your teeth come in contact with:
    - ☐ Hot foods or liquids
    - ☐ Cold foods or liquids
    - ☐ Sour foods
    - ☐ Sweet foods
- ☐ Take fluoride supplements
- ☐ Clench or grind your teeth frequently
- ☐ Jaw gets stuck so that you can't open freely
- ☐ Pain when you chew or open wide to take a bite
- ☐ Earaches or pain in front of your ears
- ☐ Jaw symptoms or headaches upon awaking in the morning
- ☐ Take medications for pain or discomfort (pain relievers, muscle relaxants, antidepressants)
- ☐ Temporomandibular (jaw) disorder (TMD)
- ☐ Pain in the face, cheeks, jaws, joints, throat, or temples
- ☐ Unable to open your mouth as far as you want
- ☐ Aware of an uncomfortable bite
- ☐ Had a blow to the jaw (trauma)

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Assignment of Benefits

Our office will accept an assignment of benefits from your insurance company with the provisions listed below. It is important to understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our office policies governing insurance claims.

- Although we are willing to complete insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms and filing to your insurance company on your behalf is a courtesy we extend to you in an effort to save you time and to facilitate payment to our office from your insurance company. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or other necessary assignment documents that may be requires by your insurance company. This instructs your insurance company to make payments directly to our office.
- We require you to pay the estimated co-payment, which is the amount not covered by your insurance company, at the time treatment is rendered. **The co-payment is ONLY an estimate of charges and may be found to be insufficient after review by your insurance company.**
- Insurance payments are ordinarily received within 30-40 business days from the time of filing the claim. **If your insurance company does not pay within 90 days, you will be responsible for the entire balance at that time.** You will be reimbursed if payment is made afterwards.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if for any reason your claim is denied, you will be responsible for paying the full amount for the treatment rendered.
- Returned checks are subject to a **$50** admin fee. All balance older than 60 days will be subject to a collection action fee.
- There is a **$75** charge for all no-show and cancellations of scheduled dental appointments WITHOUT **a 24 hour notice**.
- We respect our patients' time so in order to provide timely, professional care, we do have a 15 minute rescheduling policy. Patients who are **15 minutes late** to their scheduled appointments will be rescheduled.

I HAVE READ AND ACCEPTED THE TERMS AND CONFITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT AND OFFICE POLICY. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO DR. KAMILA HUSAIN.

Patient/Guardian Signature: _____ Date: _____

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Consent for Use Disclosure of Health Information

Purpose of consent: By signing this form, you will consent to our use and disclosure of your health information to carry out treatment, payment activities, and health operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Dr. Kamila Husain DDS and/or Staff at 1013 Dairy Ashford Rd. Houston, TX 77079, (713)800-4200 smile@usparkledental.com

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____, have fully had the opportunity to read and consider the contents of this consent form. I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and healthcare operations.

Signature: _____

Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

I consent that Dr. Kamila Husain may use photographs of me on their social media page which includes but is not limited to their Facebook page. I understand that these images will not be used for any other commercial purposes.

_____ Initial

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INFORMED CONSENT FOR XRAYS, EXAM, AND CLEANING

I authorize Dr. Kamila Husain and her staff to perform an examination, which may include x-rays. If diagnosed with a prophy (regular cleaning), I authorize to have the procedure done.

CHANGES IN TREATMENT PLAN

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

INFORMED CONSENT FOR RADIOGRAPHS (X-RAYS)

This office follows the guidelines of the American Dental Association and recommends that FULL MOUTH X-RAYS (FMX) BE TAKEN ONCE EVERY 3 TO 5 YEARS and BITEWING X-RAYS every 6 months for caries active patients and 1-2 years for routine cases. Current x-rays will be necessary before any diagnosis can be finalized. NO TEETH WILL BE EXTRACTED without a current PA (periapical x-ray showing the root and surrounding bone and soft tissue). No fillings be placed without current bitewings and/or PAs of the tooth. NO EXCEPTIONS.

CHILDREN AND ADULTS: If any decay or dental infection (abscess) is obvious on visual inspection, x-rays will be necessary to assess the extend of damage to the tooth structure. If your child is uncooperative, you will be referred to a pediatric dentist for treatment. Bitewings and occlusal films are recommended for school age children 5 years and up. Bitewing x-rays may be suggested at age 3.5 to 4 years if there is no spacing between the teeth and if we suspect caries.

PREGNANT WOMEN: X-RAYS WILL BE AVOIDED UNLESS IT IS AN EMERGENCY. Please inform the office if you think you are pregnant and x-rays will be postponed.

X-rays are used to diagnose 1.) the extent of bone loss associated with PERIODONTAL DISEASE 2.) interproximal caries – decay in between the teeth 3.) pathology of pulp 4.) integrity of root canal fillings 5.) verify tooth or root structure 6.) supernumerary teeth or impacted teeth 7.) pathologic root resorption 8.) third molar location and position 9.) bone pathology 10.) need for interceptive orthopedic/orthodontic treatment. This will become important if you ever have trauma to your face and teeth due to an auto/bike accident or sports injury for example.

ROUTINE CLEANING

Treatment involves removing the bacterial substance known as plaque, which is the principal cause of periodontal disease and calculus, which is an accumulation of hard deposits on the tooth above the gingival margin. I understand that my gums may bleed or swell, and I may experience moderate discomfort for several hours. There may be slight soreness for a few days. I will notify the office if conditions persist beyond a few days. I understand that because cleanings involve contact with bacteria and infected tissue in my mouth, I may also experience an infection, which would be treated with antibiotics. I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days afterwards. However, this can occasionally be an indication of a further problem. I must notify if this or other concerns arise. I understand that as my gum tissues heal, they may shrink somewhat, exposing some of the root surface. This could make my teeth more sensitive to hot or cold. I understand that I may receive a local anesthetic and/or other medication. In rare instances patients may have a reaction to the anesthetic, which could require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the normal chance of swallowing foreign objects during treatment. Depending on the anesthesia and medication administered, I may need a designated driver to take me home. Rarely, temporary or permanent nerve injury can result from an injection.

_____ _____

Patient or Responsible Party Signature Date

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Thank you for choosing U Sparkle Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Cash, Check, Visa, MasterCard, or Discover Card
- We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $1,500 or more
- NO INTEREST Payment Plans from Care Credit (up to 12 months):
    - Allows you to pay overtime with NO INTEREST
    - Convenient, low monthly payment plans are also available
    - No annual fees

Please note:

Our dental practice requires payment prior to the beginning of your treatment.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

A fee of $75 is charged to patients who miss or cancel an appointment without a 24 hour notice.

Our dental practice charges $50 for all returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)