We are pleased to welcome you and your child 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. We look forward to working with your child.

PATIENT INFORMATION

Child's Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ School _____

Grade _____ Hobbies/Sports _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Cell Phone _____

Business Phone _____ Email _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Child _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from child)* _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____ Business Email _____

Insurance Company _____ Phone _____ Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is child covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Child _____ Birthdate _____

Address *(if different from child)* _____ Soc. Sec. # _____

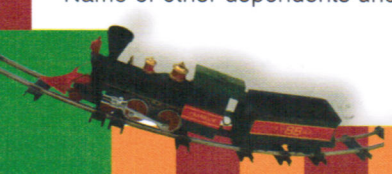
City _____ State _____ Zip _____ Home Phone _____

Subscriber Employed by _____ Business Phone _____ Business Email _____

Insurance Company _____ Phone _____ Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____



Please complete both sides.

DENTAL HISTORY

What would you like us to do for your child today? _____

_____

Former Dentist _____ Address _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? ❑ Y ❑ N

Has your child ever experienced a mouth or chin injury? ❑ Y ❑ N

Does your child have speech problems? _____

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your child's dental health or previous treatment _____

_____

MEDICAL HISTORY

Child's Physician _____ Phone _____

Date of last visit _____ Has your child had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Is your child currently under physician care? ❑ Y ❑ N If yes, describe _____

Has your child ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Has your child ever taken Fen-Phen/Redux? ❑ Y ❑ N

Check (✓) if your child has had any of the following:

- ❑ AIDS/HIV Positive
- ❑ Anemia
- ❑ Asthma
- ❑ Atopic (allergy prone)
- ❑ Blood disease
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Convulsions/Epilepsy
- ❑ Cough, persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Food allergies
- ❑ Headaches
- ❑ Hearing Impairment
- ❑ Heart problems Describe _____
- ❑ Hemophilia/Abnormal bleeding
- ❑ Immunizations current
- ❑ Kidney disease or malfunction
- ❑ Liver disease
- ❑ Material allergies (**latex**, wool, metal, chemicals)
- ❑ Respiratory disease
- ❑ Rheumatic/Scarlet fever
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Skin rash
- ❑ Spina Bifida
- ❑ Thyroid disease or malfunction
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Other _____

List medications your child is taking, if any:

List drug allergies, if any:

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

MAZIN NAKHLEH, D.D.S.
11411 N. Central Expy, Suite 100
Dallas, Texas 75243
Tel: 214.340.9696, Fax: 214.340.0413

Welcome!

Thank you for selecting our practice to assist you with your dental health needs! Our team of professionals is committed to providing the highest quality services possible with personalized touch!

IMPORTANT INFORMATION

1. Appointments are available six days a week, Monday through Saturday. For your convenience and to serve emergency needs, we offer a 24-hour phone line.

2. Appointment times are reserved exclusively for you. To ensure that this time is convenient, **we require verbal confirmation 2 weeks** in advance for hygiene, and **1 week in advance** for doctor treatment. A reminder call will follow. To avoid a $75.00 cancellation fee, we ask for 48-hour notice if you are unable to make your appointment, and a 7 day advanced cancellation notice for Saturday appointments.

3. Payment is expected in full at each appointment. We accept the following major credit cards: MasterCard, Visa, Discover/Novus, and American Express. If you have questions concerning fees or payments, feel free to speak to front desk personnel. Please do not discuss fees or arrangement with Dr. Nakhleh, as he is here to serve your dental needs.

4. As a courtesy to our patients, we can file dental charges directly to your insurance company. The portion **not covered** by insurance will need to be paid by the patient at the time of treatment. **Any outstanding balances are due in full within 30 days after treatment. Payment not received within 60 days is delinquent.**

5. Please note that dental insurance is never a pay-all, it is only an aid. It is realistic to expect insurance to cover 35 percent to 65 percent of all major services. Many routine dental services are not covered by insurance. Should you have questions regarding your dental insurance benefits, please contact your employer or insurance company directly.

6. For the protection and safety of your child, we ask that all children under the age of 12 years be accompanied by a parent AT ALL TIMES in the waiting room. Also, because of exposure to toxic chemicals, x-rays, and sharp instruments, children are not permitted beyond the waiting room door if they do not have an appointment. We hope you understand that this policy is put into place for the benefit of your child. Thank you for your compliance.

We are delighted to welcome you into our practice and look forward to serving you!

Signature_____Date_____

Sandra L. McCarthy, D.D.S. Prosthodonotist
Mazin Nakhleh, D.D.S. General Dentistry
Debra Frankfurt, D.D.S. General Dentistry

Tel: (214)340-9696 Fax: (214)340-0413 11411 N. Central Expy., Suite #100, Dallas, TX 75243

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my-private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date: _____ Initials: _____ Reason: _____