siranli
implants + facial aesthetics
prosthodontics

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WELCOME TO OUR PRACTICE. Our goal is to help you reach and maintain maximum oral health. Please fill out this chart completely. The better we communicate, the better we can care for you.

Today's date:_____whom may we thank for referring you? _____

Name:____|_____|____|_____ I prefer to be called:_____
MR MRS MS DR FIRST M. Last

Birth-date_____/_____/_____SSN #: _____

Gender: M or F or U ____ Single____Married____Divorced____Widowed

Home address: _____
Street City State Zip

Home #:_____Cell #:_____Work #:_____Ext_____

Email address:_____@_____

Do we see other family members? (Name) _____

Driver License State ID #: _____

Employer:_____Occupation:_____

Work Address: _____

Spouse Name:_____Birth-date:_____SSN#_____

Employer:_____Work #:_____Ext.: _____

In the event of an emergency, is there someone whom we should contact other than your spouse?

Name:_____Relation:_____Home #: _____

Other #:_____Can We give Medical Details: Yes or No

_____ Please See Back Side _____

DENTAL INSURANCE: Policyholder name:_____ Birth-date:_____
Ins. Co. Name:_____ Phone #:_____ Group #:_____ ID#_____

Ins. Co. Address:_____
Street or PO Box # City State Zip

Do you have a Secondary Ins Policy: Yes or NO If yes, please submit give a copy of the front the desk.

If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance Claim forms and verifying coverage before your procedure. We file to most insurance companies however we are fee for service. This means that you are responsible for payment at the time of services regardless of whether your dental insurance approves the dental procedures or covers them. We will submit your claim to your insurance and you may receive payment directly from your ins. company as they see fit. *Remember however, you are responsible for the **total** treatment fee regardless of what commitments you have with your own insurance. Please feel free to ask our office about other payment options if this is an issue.*

CONTRACTUAL AGREEMENT: PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW

This agreement is between the undersigned and Siranli Dental (the "Contract"). I understand all patient portions are due and payable at the time services are rendered. I authorize payment directly to Siranli Dental for the benefit otherwise payable to me under the terms of any insurance. I understand I am financially responsible for all charges arising from the treatment of the below-named patient and any insurance payments will be credited to the account. **In the event** the bank returns any check given in payment on this account unpaid for any reason, a $30.00 charge will be added to the account balance each time such a check is returned. **If all charges** are not paid in full within sixty (60) days from the date of service I agree to pay the service charge of 1.8% per month, twenty-one (21%) per annum, interest on the unpaid balance (the "Default Interest Rate"), along with a $5.00 late charge. A payment is late if it is not received within sixty (60) days of the date the service was performed (the "Late Payment"). A sum of money only constitutes a "payment" when that sum is successfully deposited by Siranli Dental, clears the account, and is not involuntarily transferred away. I agree that Siranli Dental has the option but not the obligation to find me in default under this Contract, without notice, as a result of a Late Payment or any other violation of the terms of the Contract (the "Default"). Siranli Dental acceptance of a Late Payment does not revoke a Default under the Contract absent written consent from Siranli Dental.

If this account is referred to an attorney for collection, I agree to pay all costs of collection, including, but not limited to, an additional thirty-three and one-third of total balance owed for attorney's fees, in addition to all court costs. Late Payments shall be applied first to attorneys' fees, second to interest accrued at the time of payment, third to principal. Any term of the Contract that may be found unlawful shall be stricken, and the remainder of the Contract shall remain fully enforceable and in effect.

I understand, in accordance with D.C. Mun. Regs. tit. 22-B, § 211, as amended, that if the provision health care services to the patient at this office directly exposes any person by or under the direction and control of the health care provider to the patient's body fluids in a manner which may transmit immunodeficiency virus or HIV, then the patient shall be deemed to have consented to testing for infection with HIV and to the release of such tests results to the persons exposed.

I further understand that I will be charged a minimum fee of $50 per one-half (1/2) hour for all missed or cancelled appointments unless forty-eight hour notice is given.

Name:_____ Relationship to patient: _____

SIGNATURE:_____ Date: _____

Witness: (Siranli Dental Employee) _____

PATIENT NAME: _____

Medical Information: Primary Care Physician's name:_____Phone #: _____

Date of last visit:_____Current physical health (*circle one*) good fair poor
Are you currently under the care of a physician?____If yes, explain reason. _____
Y/N

Are you taking any medications, vitamins, and supplement? Y / N Please list each one. _____

_____

Have you ever had any of the following medical conditions? ***(Please circle Y or N for each)***

It is important that you alert us of ALL your medical conditions.

Y N Abnormal Bleeding
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial bones or joints
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Colitis
Y N DENTAL ANXIETY
Y N Drug Use
Y N Diabetes
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fever Blisters
Y N Frequent Headaches
Y N Glaucoma
Y N Heart Murmur
Y N Heart Trouble
Y N Hemophilia
Y N Hepatitis
Y N High Blood Pressure
Y N HIV+/Aids
Y N HPV
Y N Kidney Problems
Y N Jaw Pain
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Rheumatic Fever
Y N Stroke
Y N Shingles
Y N Sinus Problems
Y N Thyroid Condition
Y N Tobacco Use (____a day)
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease
Y N Other

_____

Covid-19 Vaccination:_____ Pfizer_____Moderna_____J&J_____Booster

For Women: Are you taking birth control pills?____Are you nursing?_____Are you pregnant? _____

Please describe any conditions indicated above: _____

_____

Are you allergic to any of the following? ***(Please circle Y or N for each.)***

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Sulfa Drugs
Y N Tetracycline
Y N Other

Dental History: Why have you come to the dentist today? _____
Previous / Present Dentist:_____Date of last visit: _____
Have you ever had a serious / difficult problem associated with any previous dental work? YES or NO If yes, please explain:_____
Your current dental health is? __Good __Fair __Poor
Your toothbrush bristles are? __Hard __Medium __Soft
How often do you brush? _____
Do you like your smile? YES or NO
Do your gums ever bleed? YES or NO
Floss? YES or NO

AUTHORIZATION: I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the dental team to perform any necessary dental services, with my informed consent, that I may need during diagnosis and treatment.

INITALS:_____**Date**: _____

OFFICE USE ONLY: verbally reviewed the medical / dental information above with the patient named herein.
Initials ____

Dental X-ray Consent Form

Dental x-rays allow the dentist to diagnose and treat conditions that cannot be detected during a clinical examination. Our office use Dental x-ray films detect much more than cavities. For example, x-rays may be needed to survey erupting teeth, diagnosing bone diseases, evaluate the results of an injury, or to plan for surgical treatment.

If dental problems are found and treated early, before they become visible or painful, dental care is much more comfortable and affordable. Dental x-rays are a part of a comprehensive oral examination and are recommended ONCE a year. Our office may reserves the right to not treat patients who declines Dental X-rays. If you decide to opt out please ask a staff member for an X-ray refusal form. You dental insurance may or may not cover the fee of some x-rays.

Our offices use Digital X-rays, which are checked quarterly by Certified Dental Dosimeter. This is used to ensure the lowest possible amount of radiation. FDA study have shown Dental radiographs account for approximately 2.5 percent of the effective dose received from medical radiographs and fluoroscopies.

INITALS: _____

Photography Release Consent

I hereby authorize Siranli Dental to publish Photographs taken of me for the use of Siranli Dental's prints, online and video based patient library.

I herby release and hold Siranli Dental harmless from any reasonable expectations, of privacy or confidentiality associated with images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photograph or participation in company marketing materials or other company publications. I acknowledge and agree that publication of said photos confer on rights of ownership or royalties what's whatsoever.

I hereby release Siranli Dental, its Contractors, its employees, and any third parties involved in the creation or production of marketing materials from liability for any claims, by myself, or any third parties in connection with any participation.

(Please check one)____YES, you may use my photos._____NO, Do not use my photos

If you checked YES how would you like your name to appear?

(Please Check One)____First Name/Last Name____Initials Only_____No Name

SIGNATURE:_____**Date:** _____

_____ Please See Back Side _____

Patient Authorization For Release of Health Information To Third Party (HIPPA Form)

I understand that this authorization is strictly voluntary, and that the information to be disclosed is to disclosed is protected by law, and the use/disclosure is to be made to conform to my direction, the information that is used and/or disclosed to the pursuant (s) may be re-disclosed by the recipient by the recipient to limit the use and/or disclosure of confidential protected dental and financial information.

I authorize the release of my confidential protected dental information and financial information to the following people.

Spouse: Yes or No Spouse's Name _____

Other: (Please specify below)

Name_____ Relationship: _____

Name_____ Relationship: _____

Name_____ Relationship: _____

I authorize Siranli Dental to disclose my information to the person (s) above regarding:

Please Check All that Apply:

_____ Health Information
_____ Financial Information
_____ Insurance Information
_____ Medical Records (Releases and pick up form)
_____ History of Visits
_____ Other (please explain below)

_____

_____

_____

I understand that this AUTHORIZATION IS VALID FOR TWO YEARS from the signed date below or until_____(Requested Date) and may be revoked by me at any time except to the extent Siranli Dental has already taken action based on my authorization.

_____ _____

(Please Print of Patient or Legal Guardian) (Signature of Patient or Legal Guardian)

Date _____