TÜTH DENTAL
2020 S Fry Rd. Suite I, Katy, TX 77450
+281 717.4928 | info@tuthdental.com

TÜTH DENTAL NEW PATIENT

Intake Form Date: _____

Name: _____ Birth date: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____ Email: _____

Sex: ○ M ○ F Marital status: ○ Single ○ Married ○ Divorced ○ Separated ○ Partnership ○ Minor

Employer or School: _____ Phone: _____

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

Spouse, partner or parent name: _____

Person to contact in case of an emergency: _____ Phone: _____

How did you learn about TÜTH Dental or whom may we thank for referring you? _____

Who is responsible for your account and payment? (If different from previous listing): _____

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

Phone: _____ Email: _____ Birth date: _____

Insurance information Insurance company: _____ Phone # _____

Subscriber's Social Security # _____ Group # _____ ID # _____

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

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

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

Secondary dental insurance Insurance company: _____ Phone #: _____

TÜTH Dental reserves the right to not submit for secondary insurance and will provide you with documentation to do this.

Your Social Security # _____ Group # _____ ID # _____

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

How much is your deductible? _____ How much have you used? _____ What is your annual maximum benefit? _____

Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____

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

Dental history

Reason for today's visit to TÜTH Dental: _____

Date of last dental care visit: _____ Date of last dental x-rays: _____ Former dentist's name: _____

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

Phone: _____

Check if you have any problem with the following:

- ○ Bad breath
- ○ Bleeding gums
- ○ Clicking or popping jaw
- ○ Food collection between certain teeth
- ○ Grinding teeth
- ○ Loose teeth or broken fillings
- ○ Periodontal treatment
- ○ Sensitivity to any of the following: cold, hot, sweets, biting
- ○ Sores or growth in your mouth

How often do you floss? _____ How often do you brush? _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. We truly appreciate your willingness to answer the following questions.

Medical History

Your physician: name: _____ Date of last visit: _____

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? These include combinations of loimin, Adipex, Fastin (brand name of phentermine) Pondimin (fenfluramine) and Redux (dexfenfluramine). ○ Yes ○ No

Have you had any serious illnesses or operations? ○ Yes ○ No

If yes, describe: _____

Have you ever had a blood transfusion? ○ Yes ○ No

If yes, give approximate dates: _____

Women: are you pregnant? ○ Yes ○ No Are you nursing? ○ Yes ○ No Are you taking birth control? ○ Yes ○ No

Are you allergic to any of the following?

○ Acrylic
○ Aspirin
○ Codeine
○ Latex
○ Metal
○ Penicillin
○ Sulfa drugs
○ Other

If yes, please explain: _____ _____

Check if you have or have had any of the following:

○ AIDS / HIV positive
○ Alzheimer's disease
○ Anaphylaxis
○ Anemia
○ Angina
○ Arthritis, rheumatism
○ Artificial heart valves
○ Artificial joints, pins, etc.
○ Asthma
○ Bleeding abnormally
○ Blood disease
○ Blood transfusion
○ Bruise easily
○ Cancer
○ Chemical dependency
○ Chemotherapy
○ Circulatory problems
○ Cold sores / Fever Blisters
○ Congenital heart lesions
○ Convulsions
○ Diabetes
○ Drug addiction
○ Emphysema
○ Epilepsy
○ Fainting
○ Genital herpes
○ Glaucoma
○ Hay fever
○ Headaches
○ Heart attack/failure
○ Heart murmur
○ Heart pacemaker
○ Heart trouble/disease
○ Hemophilia
○ Hepatitis A
○ Hepatitis B or C
○ Herpes
○ High blood pressure
○ High cholesterol
○ Hives or rush
○ Hypoglycemia
○ Jaw pain
○ Irregular heartbeat
○ Kidney disease
○ Leukemia
○ Liver disease
○ Low blood pressure
○ Lung disease
○ Mitral valve prolapse
○ Osteoporosis
○ Pacemaker
○ Pain in jaw joints
○ Parathyroid disease
○ Psychiatric care
○ Radiation treatment
○ Recent weight Loss
○ Renal dialysis
○ Respiratory disease
○ Rheumatic fever
○ Rheumatism
○ Scarlet fever
○ Sexually transmitted disease
○ Shingles
○ Sickle cell disease
○ Sinus trouble
○ Spina bifida
○ Stomach/Intestinal disease
○ Stroke
○ Swelling of feet or ankles
○ Thyroid problems
○ Tobacco use
○ Tonsillitis
○ Tuberculosis
○ Tumors or growths
○ Ulcers

Have you ever had any serious illness not listed above? ○ Yes ○ No _____

List medications you are currently taking and the correlating diagnosis: _____

_____

_____

_____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health. I certify that I and/or my dependent/s have insurance coverage with _____ and assign directly to Dr. Taline Aghajanian all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

Dr. Aghajanian may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. This consent will continue as long as I am a patient with Dr. Aghajanian.

Signature of patient (parent, guardian or person representative) _____ Date: _____

Print name of patient (parent, guardian or person representative) _____ Date: _____

Payment is due at the time of services unless prior arrangements have been made and approved.

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FINANCIAL & INSURANCE AGREEMENT

Intake Form Date: _____

We are committed to providing you with the best possible dental care. We would like you to be informed of our office financial and insurance policy. Payments are expected at the time services are rendered. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits only for the services performed. To maintain the practice operation and to prevent potential misunderstanding, we ask patients to accept and adhere to financial arrangements regarding their dental treatment.

We accept cash and credit card payments. In addition, we offer an excellent third party financial payment plan for balances over $600.00. Our office staff would be more than happy to provide you with more detailed information on this plan.

If you have dental insurance, please provide us with your complete insurance information and we will gladly process your claim for reimbursement as a courtesy to you. We accept assignment of insurance benefits: however, please be aware of the following:

1. Your insurance is a contract between you , your insurance carrier and your employer. WE ARE NOT A PART OF THAT CONTRACT; THEREFORE, OUR FINANCIAL RELATIONSHIP IS WITH YOU AND NOT YOUR INSURANCE COMPANY.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for services, along with unpaid deductibles and co-payments are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 60 days, we will require you to pay the balance due using cash, master card, visa or discover.
5. If your insurance overpays us, we are to receive payment by such before providing you with a refund amount. Amount cannot exceed your money you have currently paid for the service.

We must emphasize that, as dental care providers, our relationship is with you the patient, not your insurance company. We realize that temporary financial problems may affect timely payments of your account; if such situations do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information, please do not hesitate to ask us. We are here to assist you with any questions or concerns you may have.

I HAVE READ THE OFFICE FINANCIAL POLICY OF TÜTH DENTAL - TALINE AGHAJANIAN DDS PLLC. I UNDERSTAND AND AGREE TO THIS POLICY AND HAVE HAD ALL MY QUESTIONS ANSWERED.

Signature of Patient (Guardian): _____ Date: _____

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MEDIA / HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____

TÜTH Dental facility: 2020 S Fry Rd, Suite I, Katy TX 77450

I hereby authorize TÜTH Dental, its subsidiaries, and any related organizations (Taline Aghajanian DDS PLLC) to use and disclose information about me for the purposes of creating press releases, news stories, photographs or video clips, website and/or publications, as well as stand-alone pictures/graphics in which I may appear and/or be heard, for use in internal TÜTH Dental publications and/or disclosure to external (non-TÜTH Dental) media.

The information about me may include my: name, treatment, age, duration of treatment, treatment plan, diagnoses, city and state of residence, photographs, location of TÜTH Dental treating facility and information about my life and how I came to TÜTH Dental, my on-going treatment. The information may also be disclosed to external media in the form of press releases, stories, photographs or video clips. It may also be used for internal purposes or on the TÜTH Dental website or through TÜTH Dental's own marketing or educational campaigns. TÜTH Dental will not receive any direct or indirect payment from or on behalf of any third party in exchange for the release of this information about me.

I understand the provision of health care treatment, payment for my health care and my health care benefits are not dependent on this authorization. I understand I am not required to sign this authorization, however the information will not be used or disclosed without authorization. I understand any information used or disclosed pursuant to this authorization may be subject to redisclosure.

I understand I have the right to revoke this authorization in writing, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by sending correspondence to the Facility Administrator of the TÜTH Dental facility listed above.

I hereby release, discharge and agree to hold TÜTH Dental harmless from any liability that may arise from the release of information authorized above.

This authorization shall expire 10 years from date of signature.

_____ _____

Date Signature of Patient or Personal Representative

_____

Print Name

If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the Patient named above and I am not prohibited by Court Order from releasing access to the requested information.

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PATIENT CONSENT AND RELEASE AGREEMENT

I, the undersigned, grant to TÜTH Dental and its affiliated entities, licensees, successors and assigns (collectively called the "Licensed Parties") a worldwide, perpetual right and license to use, reproduce, print, publish, broadcast and rebroadcast, as well as to copyright, my testimonial statement, voice, picture, name and likeness in any and all media and types of advertising and promotion (collectively referred to as "Advertising") for the Licensed Parties and their products and services.

All right, title, and interest in and to my name, testimonial statement, voice, picture, and likeness used in Advertising pursuant to this Consent and Release, including all copyrights therein, will be the sole property of the Licensed Parties, free from any claims whatsoever by me or my employer.

I understand that I will not have any right to compensation in connection with the Licensed Parties' use of my name, testimonial statement, voice, picture, or likeness. I hereby release the Licensed Parties and their successors and assigns from any and all claims arising out of their use of my name, testimonial statement,voice, picture, and likeness as agreed to in this document, including without limitation any claims based on libel, slander, or the rights of publicity, privacy or personality. I hereby waive any right to review any Advertising and agree that no advertisement or other material need be submitted to me for any further approval.

I acknowledge that this permission authorizes the Licensed Parties to post my testimonial statement, voice, picture, name, and likeness on third party social media web sites (including Facebook, Google+, Yelp, Twitter, Instagram, and YouTube), which may require Licensed Parties to grant the owners and users of such sites a broad license to use such materials for any purpose without notice to or approval from me.

The statements attributed to me in any testimonial I provide reflect my actual experience with the Licensed Parties and my honest opinions about the Licensed Parties and/or their products and services. I understand that I have the right to revoke this Consent and Release by delivering written revocation to a TÜTH Dental Facility Administrator; provided however that this will not impose any obligation upon the Licensed Parties to recall or destroy any materials already used, published or disclosed.

This Consent and Release does not in any way conflict with any existing commitment on my part. I am of the age of 18 or older and have the right to contract in my own name and, if applicable, on behalf of my employer with respect to this Consent and Release. I understand that the provision of health care treatment, payment for my health care, and my health care benefits are not dependent upon this Consent and Release.

I understand that this Consent and Release does not obligate the Licensed Parties to make any use of any of the rights granted herein.

Signature of Releasor: _____

Print or Type Name: _____

Date: _____