SARAH JEBREIL D.D.S.
DENTAL ESTHETICS

Patient Information Form

Today's Date ______________________________________

Legal Name: First ________________________________MI ________ Last __________________________________

Preferred Name: ____________________

Address: Street______________________________________City_____________________State______Zip______________

Phone: Home________________________________ Work ________________________Mobile ________________________

Email address: ____

Preferred method of contact: Home / Work / Cell / Email / Text Message

Is it ok to leave a personal message at your preferred method of contact? YES / NO

SSN ____**Date of Birth** ____________________

Drivers License # ____State ____________

Patient Employed By _____________________________________ Occupation _______________________Phone ____________

Address: Street ____City _____________________ State ______Zip _____________

Sex ☐ Male ☐ Female **Marital Status** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? ____

Relationship to Patient ________________________________Home Phone ________________________ Mobile Phone __________

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Name of School** ________________________________

Name of Responsible Party: First __________________________________ Last ____________________________________

Date of Birth _______________________________ **Relationship to Patient** ☐ Self ☐ Spouse ☐ Parent ☐ Other ____________

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

Address: *(if different from patient)* Street _____________________________City _____________________ State ______Zip ________

Phone: Home ____Work Mobile _____________________________________

Employer *(if different from above)* ______________________________Occupation ________________________Phone___________

Address: Street _____________________________________City ____________________ State ______Zip__________________

19742 MacArthur Blvd Ste 115 | Irvine CA 92612

Direct 949.825.6020 | www.sarahjebreilldds.com | staff@sarahjebreilldds.com

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Dental Benefit Plan Information

Primary Dental Plan Name ____Phone ____________________

Address: Street ____City _________________________ State ________Zip ___________________

Name of Insured ___________________________________ Date of Birth ______________________________ID Number _________________

Policy Number ____Patient Relationship to Insured _________________________

Secondary Dental Plan Name____Phone ___________________

Address: Street ____City ______________________ State _______Zip __________________

Name of Insured _______________________________Date of Birth ____________________ID Number ___________________

Policy Number ____Patient Relationship to Insured _________________________

Medical Plan Information

Plan Name ____Phone ________________________

Address: Street _______________________________ City _________________________ State _______ Zip ___________________________

Name of Insured _______________________________ Date of Birth ______________________________ ID Number ____________________

Policy Number _________________________________ Patient Relationship to Insured _______________Deductible Amount _____________

Whom may we thank for referring you?

☐ One of our valued patients (name of patient) ____

☐ Advertisement _____________________________________ ☐ Online ____

☐ Our Website ☐ Other ____

Please list other members of your immediate family who are patients in our practice

___________________________________ _________________________________ ______________________________

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OFFICE POLICY

Our office policies statement is designed with you, the patient, in mind. It is written to answer any questions you may have regarding how our office treats scheduled appointments, cancelled appointments, late arrivals, dental emergencies, and weekend emergencies.

Appointments
We are dedicated to staying on schedule and seeing all of our guests on time for their appointments. We do ask that our guests be on time for scheduled appointments, planning extra time for travel or filling out forms. We recommend arriving 5-10 minutes early to ease the check in process. Please be aware that dental emergencies do arise throughout the day, which may delay or extend your appointment. We are committed to treating all true dental emergencies and will advise you immediately as to the status of your appointment.

Late Policy
We expect our guests to arrive on time for their scheduled appointment. Please note that we will have to reschedule your appointment if you arrive more than 10 minutes late. If you are habitually late, 3 or more times, your appointment will need to be rescheduled, and you will be charged a fee of $50 per half-hour of your missed appointment.

Cancellations
Our practice is dedicated to quality care and exceptional service. Our doctor and team spend extensive amounts of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as other clients. If you find that you must change your appointment, we require a minimum of 48 hours notice so that we may make every effort to accommodate other clients. If proper notice is not received, a fee of $50.00 will be charged for every half hour of allotted time cancelled to your credit card on file. Consecutive missed appointments can result in being dismissed from our office.

Emergencies
If you have an urgent problem, please call our office immediately so we may see you as soon as possible. If you have an emergency after hours, please call our office for information on how to contact the doctor on call.

Weekend and After Hours
Guests of record with true dental emergencies after regular business hours, which cannot wait until the following day, should call our office for information on how to contact the doctor on call. A pager number will be left on the office answering machine.

FINANCIAL POLICY

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. If you have insurance, as a courtesy, we will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. Ultimately, however, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. If we are not contracted with your insurance carrier, we are happy to submit the claims necessary to see that you receive the full benefits of your coverage; however we cannot guarantee any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, you are directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. Your insurance company will reimburse you directly in a timely manner. If there are any complications, we will assist you with any information you may need.

We accept the following forms of payment: Cash, and most major credit cards. We offer a 5% discount for all treatment over $2000 paid in cash. In addition, we offer CareCredit and Springstone which are payment programs offering a full range of No Interest and Extended Payment Plans for treatment costs.

Payment for services is due at the time services are rendered unless prior arrangements have been made. We apologize but we do not accept personal checks.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at anytime to discuss any concerns you may have.

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UNENCRYPTED EMAIL

There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

☐ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time.

☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

AUTHORIZATIONS

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _______(initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me.
YES / NO (Circle One) _______(initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _______(initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _______(initial)

DEPOSIT

Due to the extensive amount of time our staff and doctor devote to preparing and reserving uninterrupted time for reservations over 2 hours, we require a deposit of half of the treatment fee to make your reservation. Thank you for understanding our Office and Financial Policy.
I have read and agree to the Office Policies and the Financial Polices of Sarah Jebreil D.D.S. Dental Esthetics. I agree to a credit card on file that may be charged for violation of these policies or upon my approval for services rendered.

Credit Card Number_______________________________________ CDC code___________ Exp Date_______________________

Signature of Guest or Responsible Party: ___________________________________ Date:__________