



Artin Sakhaee D.D.S  
 Michael Baharestani D.D.S  
 Melvyn Topel D.D.S  
 Iren Sedaghatpour D.D.S  
 283 Commack Road STE 120  
 Commack, NY 11725  
 CommackDentalDesign@gmail.com  
 CommackDentalDesign.com

Date: \_\_\_\_\_

## Welcome Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email\*: \_\_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_

Work: (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharm. Telephone#: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Responsible Party DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Employer: \_\_\_\_\_

In the event of an emergency, who may we contact?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_

Primary Insurance Co: _____
Insurance Co. Address: _____ City: _____
State: _____ Zip: _____ Group #: _____
Insured's Name: _____ Relation: _____
Insured's Date of Birth: _____ Insured's ID#: _____
Insured's Employer: _____
Employer's Address: _____
Secondary Insurance Co: (if applicable) _____
Insurance Address: _____
Group #: _____ Insured's Name: _____ Relation: _____
Insured's Date of Birth: ____/____/____ Insured's Employer: _____

Medical History

Do you have a personal physician? YES or NO

Physician's Name: \_\_\_\_\_ City: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

Are you currently under the care of your physician? YES or NO

If yes, explain:

Are you currently taking any prescription/over the counter or supplemental drugs? YES or NO

Are you under treatment for osteoporosis or taking any osteoporosis medications? YES or NO

Please list all medications:

Do you smoke or use tobacco in any other form? YES or NO

Females only

If you are women are you taking birth control? YES or NO

Are you pregnant? YES \_\_\_ NO \_\_\_ UNSURE \_\_\_ Week#: \_\_\_\_\_ Are you nursing? \_\_\_\_\_

Have you ever had any one the following diseases or medical problems?

(Please circle all that apply or write NONE)

- |                                  |                                    |
|----------------------------------|------------------------------------|
| Anemia                           | Epilepsy/ Seizures/ Fainting spell |
| Artificial Bones/ Joints/ Valves | Fever Blisters/ Herpes             |
| Arthritis                        | Heart Attack/ Stroke               |
| Asthma                           | Heart Murmur                       |
| Blood Transfusion                | Heart surgery/ Pacemaker           |
| Cancer/ Chemotherapy             | Hemophilia/ abnormal bleeding      |
| Diabetes                         | Hepatitis                          |
| Difficulty Breathing             | High/Low Blood Pressure            |
| Drug/ Alcohol Abuse              | HIV+/ AIDS                         |
| Emphysema/ Glaucoma              | Hospitalization for any reason     |
| Mitral valve prolapsed           | Kidney problems                    |
| Psychiatric problem              | Shingles                           |
| Rheumatic/ scarlet fever         | Sinus Problems                     |
| Severe/ frequent headaches       | Ulcers/Colitis                     |
| Tuberculosis                     | VenerealDisease                    |

Please list any serious medical conditions that you have ever had.

Please list any surgeries you have ever had.

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Are you allergic to any of the following? (Please circle all that apply)

Y N -Aspirin

Y N -Erythromycin

Y N -Penicillin

Y N -Codeine

Y N -Jewelry/Metals

Y N -Tetracycline

Y N -Dental Anesthetics

Y N -Latex

Y N -Other

Please List any other drugs/materials that you are allergic to. \_\_\_\_\_

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Please explain to us why have you come to the dentist today? \_\_\_\_\_

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Are you currently in pain? \_\_\_\_\_ Do you require antibiotics before dental treatment? YES or NO

If so what for? \_\_\_\_\_

Please list your Pharmacies address and telephone number

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information to inform this office of any changes in my responsibility in inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

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Signature

Date



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## PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Print Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_



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### **Financial Responsibility & Assignment of Benefits**

*I understand that insurance billing is provided as a courtesy and that I am financially responsible to Commack Dental Design, PLLC for all charges arising from my treatment. It is my responsibility to notify Commack Dental Design, PLLC of any changes in my health care coverage. While Commack Dental Design, PLLC verifies my insurance eligibility, exact insurance benefits cannot be determined until the health plan receives the claim. I agree to accept financial responsibility for all medical services or supplies receive by me. I authorize direct payment from my health insurance plan to Commack Dental Design, PLLC for all services and supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as workers' compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer.*

#### *Cancellation Policy*

*We understand that circumstances may arise requiring you to cancel your scheduled appointment. Please try to give us a 24 hour cancellation notice.*

#### *Consent for Treatment and Release of Information*

- *I am aware of my diagnosis and wish to receive treatment from Commack Dental Design, PLLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me.*
- *I give permission to Commack Dental Design, PLLC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.*
- *I authorize Commack Dental Design, PLLC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.*
- *I certify that I have read this agreement and my signature indicates my understanding and consent.*

Date: \_\_\_\_\_

# COVID-19 Screening Form ...

Patient's name:

Date:

Date:

## PREAPPOINTMENT CHECK

## IN-OFFICE VISIT

1. Have you previously been diagnosed with COVID-19, or do you think you've had/have COVID-19?

YES  NO

YES  NO

*(If NO to question 1, skip to question 5)*

2. If YES, when and how were you confirmed positive?

- I think I had it.
- I had a positive nasal swab test.
- I had a positive blood test.
- I had a positive saliva test.
- I currently have symptoms and am waiting for a test.

3. If you have had COVID-19, how were you confirmed negative?

- I was diagnosed negative by a nasal swab test. How many times?      How far apart?
- I show antibodies to COVID-19 with a blood test.
- My doctor said I no longer have it because I don't have any symptoms.
- I don't have any symptoms, so I don't have it.

4. If you have had COVID-19, when were you confirmed negative?

- 24 hours ago       today       10 days after testing

5. Do you currently have (or have you experienced) any of the following symptoms in the past 21 days:

- |  |  |  |
|--|--|--|
| Fever  | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
|  | <i>If fever, how did you measure it?</i>                             |  |
| Fatigue (feeling tired)                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
| Altered or loss of taste/smell                             | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
| Dry cough  | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
| Trouble breathing  | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
| Shortness of breath, difficulty breathing, chest tightness | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
| Confusion  | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
| Blueish lips or face                                       | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
| Chills/repeated shaking with chills                        | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
| Muscle pain  | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
| Headache or sore throat                                    | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |
| Any other flu-like symptoms                                | YES <input type="checkbox"/> NO <input type="checkbox"/> PLEASE LIST | YES <input type="checkbox"/> NO <input type="checkbox"/> PLEASE LIST |
| GI upset or diarrhea                                       | YES <input type="checkbox"/> NO <input type="checkbox"/>             | YES <input type="checkbox"/> NO <input type="checkbox"/>             |

6. Are you in contact with anyone who has been sick and/or confirmed to be COVID-19-positive?

YES  NO

YES  NO

7. In the past 14 days have you traveled to any regions affected by COVID-19?

YES  NO

YES  NO

*Some medical conditions have been associated with more severe COVID-19 disease. The following questions are an attempt to determine your risk:*

8. Are you over age 65?

YES  NO

YES  NO

9. Do you have high blood pressure?

YES  NO

YES  NO

*If you have high blood pressure, is it controlled?*

YES  NO

YES  NO

10. Do you have diabetes?

YES  NO

YES  NO

11. Are you overweight?

YES  NO  NO ANSWER

YES  NO  NO ANSWER

12. Do you have respiratory problems?

YES  NO

YES  NO

13. Do you have any autoimmune disorders?

YES  NO

YES  NO

14. Are there any other conditions you would like to report?



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### ***Cancellation and No-Show Policy***

*Office Hours are by appointment and we do value your time. This is a private practice and not a dental “clinic”. **Appointment time is reserved for you alone.** Where appropriate, we prefer to schedule longer appointments so we can complete as much dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment please be sure that you will be able to keep it. Morning appointments are best for more complicated or extended procedures.*

*Emergency and unforeseen patient treatment problems may arise causing scheduling changes. Emergencies are expected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients may be slightly inconvenienced by this but, they will understand that this is an emergency situation. At some point, **they may need the same courtesy too!***

*We understand that scheduling conflicts may arise prohibiting you from keeping your appointment. If you cannot make your scheduled appointment please notify the office as soon as possible. We do not take cancellations after hours with messages left on the answering machine. **There will be a charge of \$50.00 for a broken appointment or cancellation with less than 24 hour notice to the office.***

***All appointments must be confirmed at least 24 hours before your appointment. We confirm through phone, email and text alerts. Failure to confirm your appointment may result in you losing your appointment time.***

*If you have any questions about our appointment cancellation and no-show policy please feel free to ask us.*

***I understand the above mentioned policy.***

*Print Name: \_\_\_\_\_*

*Signature: \_\_\_\_\_*

*Date: \_\_\_/\_\_\_/\_\_\_*