Date_____

Home Phone_____

Cell Phone_____

Work Phone_____

E-mail_____

## *Welcome to Dentistry 2000*

## PATIENT INFORMATION

NAME_____

LAST FIRST M

ADDRESS_____ CITY_____ STATE_____ ZIP_____

BIRTH DATE_____/_____/_____ SEX: M___ F___ AGE_____
SS#_____

SINGLE_____ MARRIED_____ WIDOWED_____ SEPARATED_____ DIVORCED_____

PLACE OF EMPLOYEMENT_____ OCCUPATION_____

BUISNESS ADDRESS_____ PHONE_____

EMERGENCY CONTACT_____ PHONE_____

PERSON RESPONSIBLE FOR ACCOUNT: (circle one) PATIENT MOTHER FATHER GUARDIAN

WHOM MAY WE THANK FOR REFERRING YOU?_____

## INSURANCE INFORMATION

PRIMARY INSURED

INSURANCE COMPANY PHONE

SUBSCRIBER/SSN# GROUP#

LAST NAME M

SECONDARY INSURED

INSURANCE COMPANY PHONE

SUBSCRIBER/SSN# GROUP#

LAST NAME M

DOB RELATIONSHOP TO PATIENT

ADDRESS CITY STATE ZIP

EMPLOYERS PHONE

DOB RELATIONSHOP TO PATIENT

ADDRESS CITY STATE ZIP

EMPLOYERS PHONE

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I will not hold my dentist or any member or his/her staff responsible for any errors or omissions that may have made in the completion of this form. This information will be kept confidential.

Signed_____ Date_____

(Patient/Parent or Guardian if patient is minor)

Date _____

CHART # _____

# Dentistry 2000

## DENTAL HISTORY

What is the reason for today's visit? _____

Date of last dental visit_____ Last dental cleaning_____ Last Full Mouth X-rays_____

Circle if you have had problems with any of the following;

| | | | | | |
|---|---|---|---|---|---|
| BAD BREATH | YES | NO | SENSITIVITY TO COLD | YES | NO |
| BLEEDING GUMS | YES | NO | SENSITIVITY TO HOT | YES | NO |
| CLICKING OR POPPING TEETH | YES | NO | SENSITIVITY TO SWEETS | YES | NO |
| GRINDING TEETH | YES | NO | SENSITIVITY WHEN BITING | YES | NO |
| LOOSE TEETH OR BROKEN FILLINGS | YES | NO | SORES OR GROWTH IN YOU MOUTH | YES | NO |
| PERIODONTAL TREATMENT | YES | NO | FOOD COLLECTION | YES | NO |

## MEDICAL HISTORY

Physician's name_____ Phone #_____ Date of last visit_____

Are you under medical treatment now? YES NO

Have you had any serious illnesses or operations> YES NO

Is YES, please describe_____

Have you ever had blood transfusion? YES NO

Give approximately dates_____

Women: Are you pregnant? YES NO

Nursing? YFES NO

Taking birth control pills? YES NO

Indicate which of the following you have had, or have at present. Circle "yes" or "no"" to each item.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart (surgery, attack) | YES | NO | Diabetes | YES | NO | Jaw Clicking | YES | NO |
| Chest Pain | YES | NO | Cough up Blood | YES | NO | Liver Disease | YES | NO |
| Heart Murmur | YES | NO | Thyroid Problems | YES | NO | Hepatitis A B C (circle one) | YES | NO |
| Congenital Heart Disease | YES | NO | Glaucoma | YES | NO | A.I.D.S/H.I.V. Positive | YES | NO |
| High/Low Blood Pressure | YES | NO | Emphysema | YES | NO | Cold Sores | YES | NO |
| Mitral Valve Prolapse | YES | NO | Chronic Cough | YES | NO | Fever Blisters | YES | NO |
| Artificial Heart Valve/Pacemaker | YES | NO | Tuberculosis | YES | NO | Blood Transfusion | YES | NO |
| Rheumatic Fever | YES | NO | Hay Fever | YES | NO | Sickle Cell Disease | YES | NO |
| Arthritis/Rheumatism | YES | NO | Sinus Trouble | YES | NO | Neurological Disorder | YES | NO |
| Cortisone Medicine | YES | NO | Radiation Therapy | YES | NO | Epilepsy | YES | NO |
| Back Problems | YES | NO | Chemotherapy | YES | NO | Seizures | YES | NO |
| Artificial Joints (hip, knee) | YES | NO | Tumors | YES | NO | Nervous/Anxious | YES | NO |
| Kidney Disease | YES | NO | Cancer | YES | NO | Psychiatric Care | YES | NO |
| Circulatory Problems | YES | NO | Hemophilia | YES | NO | Fainting or Dizzy Spells | YES | NO |
| Chemical Dependency | YES | NO | Blood Disease | YES | NO | Latex Allergy | YES | NO |

Are you allergic to any medications? YES NO

If YES, which medications_____

Have you ever taken Phen-Fen, Redux or Pondimin? YES NO

Are you taking any Medications, over the counter Drugs, or any recreational drugs of any kind? YES NO

If YES, please describe_____

Doctor's Signature_____ Date_____

## AUTHORIZATION AND RELEASE

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Dentist of any change in my health or medications.

Patient/Guardian Signature_____ Date_____

Periodic Medical History Update. Since your last visit, ANY CHANGES in your medical history? YES NO

DATE_____ INITIALS_____ DATE_____ INITIALS_____ DATE_____ INITIALS_____

# Dentistry 2000

## DENTAL CARE FINANCIAL POLICY

Thank you for choosing us as you dental health provider. Dr. Assadian and staff are committed to help you meet your treatment needs while maintaining a warm and friendly environment. In addition, it is important that you understand your treatment financial responsibilities in order to establish our professional relationship. The following information will help you understand our financial policy and you responsibilities.

Full payments are due at the time of treatment.
Financial arrangement must be made prior to starting any treatment.
Minor must be accompanied by an adult, or guardian, when treatment is administered.
The adult accompanying the minor (parent or guardian) is responsible for full payment at time of service.

By following this policy you will be properly informed and understand your financial obligations. In addition, we will be able to clear any questions you may have about your financial arrangement.

## INSURANCE

If you are covered by dental or any other government sponsored program, please discuss your financial arrangement with our financial coordinator prior to date of service. If you have insurance, we will help you process the documents as a courtesy to you so you may receive the maximum benefits. Your insurance is contract between you and your insurance company. We are NOT a party to this contract. In some cases, if we are provider of your insurance we will inform you as to how w will handle your claims according to our agreement with the insurance company. It is our policy not to become in involved in disputes between you and your insurance company regarding deductibles, copayments, covered charges, secondary insurance, “usual & customary fees”, etc., other than to supply with factnal information as necessary. We would like to make it clear that even if you have insurance, your insurance is not responsible for the bill or treatment charge, you are.

## MISSED/BROKEN APPOINTMENTS

Our policy is to be honest with you in the beginnings, by letting you know what we expect from our patients. It is our policy that patient with one missed/broken appointment and with less than 24 hours notice will have a charge of **$50.00** on the next visit. For credit patient, the charge will appear on the next monthly statement. We realize that unexpected circumstances do arise. However, in order to provide that quality dentistry for every patient, this office makes very effort to operate on a strict schedule. We, therefore, ask that you give us a courtesy of 24 hours advance notice, if you are unable to keep an appointment. **Excluding the weekends and holidays**.

It is considered a missed/broken appointment if you are **20 minutes** late. It will be only taken to consideration (to render services) by the front office staff, depending on the status of the back office.

As a courtesy to you we will attempt to confirm appointment **24 hours** in advance. However, in the event we cannot reach you, it is considered your responsibility to keep any schedule appointment.

Thank you for reading our Financial Policy. If you have any questions, please ask for our office financial coordinator, he/she will be happy to assist you. I have read, understand, and agree to the provisions of the financial Policy.

Signed_____ Date_____

Patient (Parent, Guardian, or person responsible)

# Dentistry 2000

## PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health are given to me under the Health Insurance Portability and accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to disclose my protected health information to carry out;

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
Obtaining payment from third party payers (e.g. my insurance company);

The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practice*, which contains a more complete description of the uses and disclosures of my protected health information, and my right under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

In an effort to control the increasing cost of dental care, any claims or disputes against this office shall be resolved by "binding arbitration". By signing this agreement, the patient agrees with the office of A.R. Assadian D.D.S Inc., that any dispute relating to dental or medical care services rendered for any condition, including any services rendered prior to that date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whenever made, (including to the full extent permitted by applicable law third parties who are not signatories to this agreement [including associates] shall be resolved by binging arbitration by the National Arbitration Fourm, under the Code of Procedure then in effect). The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the doctor, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as this section.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____