Patient Information

Patient Name: LAST _____ FIRST _____ Today's Date: _____

Gender: _____ DOB____/____/_____ Marital Status: _____ SS#:_____

Phone (Home) _____ (Work) _____ Ext._____ (Cell) _____

Address: Street_____ Email :_____

City _____ State_____ Zip Code_____

Medical History

Date of Last Dental Visit _____ **Reason for today's visit** _____

Check all that apply: PLEASE DO NOT LEAVE ANY BLANK

Yes /No	Yes/No	Yes/No	Yes/ No
☐☐ Aids/HIV	☐☐ Glaucoma	☐☐ Mental Disorders	☐☐ Tumors
☐☐ Arthritis	☐☐ Hay Fever	☐☐ Pacemaker	☐☐ Venereal Disease
☐☐ Artificial Joints	☐☐ Head Injuries	☐☐ Pregnancy Due date_____	
☐☐ Asthma	☐☐ Heart Disease	☐☐ Radiation Treatment	
☐☐ Blood Disease	☐☐ Heart Murmur	☐☐ Respiratory Problems	
☐☐ Cancer	☐☐ Hepatitis	☐☐ Rheumatic Fever	
☐☐ Diabetes	☐☐ High Blood Pressure	☐☐ Rheumatism	
☐☐ Dizziness	☐☐ Hypo/Hyperthyroidism	☐☐ Sinus Problems	
☐☐ Epilepsy	☐☐ Jaundice	☐☐ Stomach Problems	
☐☐ Excessive Bleeding	☐☐ Kidney Disease	☐☐ Stroke	
☐☐ Fainting	☐☐ Liver Disease	☐☐ Tuberculosis	

DO YOU PRE-MEDICATE FOR DENTAL APPOINTMENTS WITH ANTIBIOTICS? ___YES ___NO
IF YES WHAT MEDICATIONS? _____

PLEASE LIST ALL ALLERGIES:

_____
_____
_____

PLEASE LIST ALL PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS

_____
_____
_____

Have you ever had any complications following dental treatment? ___YES ___NO
If yes, please explain: _____

Are you now under the care of a physician? ___YES ___NO
If yes, please explain: _____

Name of Physician: _____ Phone_____

Do you have any health problems that need further clarification? ___YES___NO
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X _____ Date_____

Signature of Patient or Parent if Minor

Responsible Party Information

Full Name: _____

Social Security #: _____ Birth Date: _____

Phone(Home): _____ Phone(Cell): _____

Payment Type: Please Circle

Cash Check Visa MasterCard Discover American Express Care Credit HSA/FSA

I, the responsible party, agree to reconcile all charges on own/dependents account for all dental services rendered. **INITIAL: X**_____

Insurance Information

Insurance Company: _____ **Member #:** _____

Subscriber Name: _____ DOB: _____ SS#: _____

Relationship to Subscriber: _____

Employer Name: _____

Employer Address: _____

Street City State Zip Code

Employer Phone#: _____

Emergency Contact Information

Name: _____ Gender: _____ Phone (Cell): _____

Relationship to Patient: _____

Address: _____

Street City State Zip Code

Consent for Services/ Office Policy

I, the undersigned, herby authorize Dr. Farima Behnami , D.D.S. and Staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by her to make a thorough diagnosis of the patient's dental needs. I authorize Dr. Farima Behnami, D.D.S. to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with treatment and further authorize and consent to the employment of such assistance as she deems fit. I also understand that the use of anesthetic agent embodies a certain risk. I acknowledge that I have been advised to ask any questions I may have regarding procedures and costs.

I understand that the payment of my bill is a legal obligation. I also understand and agree that I am responsible for services rendered to my spouse and/or children. All filings of insurance papers and confirmation of insurance payments to be made by my insurance carrier are my responsibility, as is determining what providers are covered by my current insurance and/or are in my network. Any assistance in this matter granted by the above doctor and/or staff is given strictly as a courtesy and implies no responsibility on their part for determining eligibility, filing, follow through, or confirmation. In the event that this account should become delinquent and is therefore placed in the hands of an attorney for collection, I agree to pay attorney fees of 33 and 1/3% of the unpaid balance plus court costs. I understand and agree that the terms herein are reaffirmed each time services are received. I further agree to pay returned check charges of $25.00 per returned check.

I grant permission to this office and its assignees to telephone me at home or at my work to discuss matters related to this form.

APPOINTMENT POLICY

I understand that a 24 hour notice must be given for the cancellation of any appointment, failure to do so will result in a fee charged to my account based on the following schedule:

1ST missed appointment fee: $25 per ½ hour

2ND missed appointment fee: $50.00 per ½ hour

Due to appointment length. Crown and Bridge appointments require **Two Business Days** notice of cancellation.

I also understand that insurance does not cover any of the cancelled appointment fees based on the above fee schedule.

Appointment Policy. **PLEASE INITIAL: X**_____

I have read the above conditions of treatment and payment and agree to their content.

X_____ Date _____

Signature of Patient/ Responsible Party

Referral Information

Whom may we thank for referring you to our practice? __Another Patient, friend __Another patient, relative

__Dental Office __Yellow Pages __Dental Society __Internet __Work __Other_____

Name of person referring you to our office: _____