
Patient Information

Patient Name: _____ Date: _____ Male / Female
Last First MI

___ Married ___ Single ___ Child Birth Date: ___ - ___ - ___ Social Security #: ___ - ___ - ___

Address: _____
Street Apartment #

City State Zip Code

Phone: _____ Emergency Contact Phone: _____

E-Mail: _____

Employer: _____ Business Phone: ___ - ___ - _____

Driver's License # _____ State _____

Whom may we thank for referring you to our practice? _____

Responsible Party Information

___ Self ___ Spouse ___ Parent or Guardian

Name of insurance _____ ID# _____ GRP# _____ Eff. Date _____

Insurance phone # _____ Employer _____ Phone # _____

Name: _____ Date: _____
Last First MI

Birth Date: ___ - ___ - ___ Social Security #: ___ - ___ - ___

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

E-Mail: _____ Fax: _____

Address: _____
Street Apartment #

City State Zip Code

Patient's Name: _____ DOB: _____

Previous Dentist: _____ Date of Last Dental Visit: _____

Reason for this visit: _____

Have you ever had any of the following? Please check all that apply:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diet: (Special/ Restricted) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial/Leaky Heart Valve | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Growths | <input type="checkbox"/> Psychiatric/ Psychological Care | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy: Due date: _____ | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> H. I. V. Positive | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Allergic/Adverse Reaction To Medication or Any Substance, Please specify: _____ |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Do you pre-medicate with antibiotics prior to dental visits?
___ Yes ___ No |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Heart (Attack, Disease, Surgery) | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Smoke/Chew Tobacco | |
| | <input type="checkbox"/> High Blood Pressure | | |
| | <input type="checkbox"/> Jaundice | | |

• Have you ever taken any of the following osteoporosis medications: Zometa, Aredia, Fosamax or Actonel? ___ Yes ___ No

• Have you ever had any complications following dental treatment? ___ Yes ___ No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? ___ 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: _____

• Are you taking any medications? Purpose? Please list _____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct.

If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Date: _____

Signature of patient, parent, or guardian

Doctor Signature: _____

Consent for Services and Financial Information and HIPAA Information

Consent:

I hereby authorize Dr. Haidari and/or his staff to take x-rays, models, photographs, and other diagnostic aids deemed appropriate by Dr. Haidari to make a thorough diagnosis of my/my charge's dental needs. Upon such diagnosis, I authorize Dr. Haidari to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks.

I understand, acknowledge, and agree that photographs and images of me may be shown to other patients, potential patients, and doctors for treatment and educational purposes. I further understand that my name or identifying information will be kept confidential.

Financial Information:

As a courtesy, this office will help prepare and submit your insurance forms, however I understand that any fees not covered by insurance are my final responsibility. By signing this form I authorize this office to submit insurance claims and to contact my insurance company on my behalf. In consideration for the professional services rendered to me or at my request, I agree to pay for all services regardless of insurance coverage.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. A service charge of 18% per year will be charged to my account on any unpaid balance not paid the day of service, unless previously written financial arrangements are made. I understand that payment plans are available to assist with payment. I understand that in order to be approved for any payment plan options that a credit card report may be run.

I understand that in the event that I default in the payment of fees due to Dr. Haidari, I will be responsible for all expenses incurred by Dr. Haidari including, but not limited to attorney fees, collection expenses, discretionary costs and court costs associated with collecting outstanding fees. I also understand that negative payment information may be reported to credit agencies.

HIPAA Information

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and 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 Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. 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 options, 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. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

Date: _____ Relationship to Patient: _____

Signature of patient, parent, or guardian