Patient Information

Patient Name: ____ Date:_________ Male / Female

Last First MI

__ Married __ Single __ Child Birth Date: ___-___-____ Social Security #: ______-____-_______

Address:____ ______________

Street Apartment #

____ __________ __________________

City State Zip Code

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

Responsible Party Information

The following is for the person responsible for payment: __ self __spouse ___parent or guardian

Patient Name: ____ Date:_______________

Last First MI

Birth Date: ______-______-_________ Social Security #: __________-_______-____________

Phone (Home):___________________ (Work):_______________ Ext:__________ (Cell):____________________

E-Mail: ____ Fax: _____________________

Address:____ ______________

Street Apartment #

____ __________ __________________

City State Zip Code

Driver's License # _______________________ State ______________

Insurance Information

Insurance Plan Name ____________________________ Insurance Telephone: ___________________

ID #: _________________________ Group #: ____________________ Policy Holder's Birth Date: ____-___-_______

Policy Holder's Employer: ____

Employer's Address: :____

Street City State Zip Code

Name of Policy Holder: ___________________________________ Patient at our office? Y or N

Last First MI

Insurance Company's Address : ____

Street City State Zip Code

Policy Holder's Phone (Home):_______________ (Work):________________________ (Cell)______________________

Patient's relationship to policy holder: ___ Self ___ Spouse ___ Child ___ Other (specify) ___________

Health History Update

Patient's Name: ____

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

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

- 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

____ Date:__________________

Dr 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 play 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