PATIENT INFORMATION

Patient Name_____ Date_____

Address_____ City_____ Zip_____

Home Phone_____ Cell Phone_____Email_____

SSN_____ Birthdate_____ Female □ Male □

Employed by_____Work Phone_____

How did you hear about this Office?_____

Emergency Contact Name_____Relationship_____Phone_____

RESPONSIBLE INFORMATION

Dental Insurance_____Group_____ Employer_____

Subscriber_____Phone_____ SSN_____ Birthdate_____

MEDICAL HISTORY

I consider my health to be (please check one) ☐Excellent ☐Good ☐Fair ☐Poor

Do you or have you had any of the following? Please circle Y for yes or N for No.

Y	N	Abnormal Blood Pressure	Y	N	Herpes
Y	N	AIDS	Y	N	History of Drug Addiction
Y	N	Anemia	Y	N	History of Emotional or Nervous Disorders
Y	N	Arthritis	Y	N	Immune Suppressed Disorder
Y	N	Asthma	Y	N	Implants/Artificial Joints
Y	N	Cancer/Chemotherapy	Y	N	Infectious Mononucleosis (Mono)
Y	N	Congenital Heart Lesions	Y	N	Jaundice
Y	N	Diabetes	Y	N	Kidney Disease
Y	N	Epilepsy/Seizures	Y	N	Liver Disease
Y	N	Excessive Bleeding	Y	N	Prolonged Bleeding Disorder
Y	N	Excessive Urination and/or Thirst	Y	N	Radiation Treatment
Y	N	Fainting Spells	Y	N	Rheumatic Fever
Y	N	Glaucoma	Y	N	Sexually Transmitted/Venereal Disease
Y	N	Hay fever	Y	N	Sinus Trouble
Y	N	Hearing Loss	Y	N	Stroke
Y	N	Heart Disease	Y	N	Tuberculosis or Lung Disease
Y	N	Heart Murmur/Mitral Valve Prolapse	Y	N	Tumor or Malignancy
Y	N	Hepatitis Type_____	Y	N	Ulcers
Y	N	I have consumed alcohol within the last 24hrs			
Y	N	Have you ever taken Fen-Phen or Redux?			
Y	N	Do you smoke or use tobacco			

Doctors Notes Only:

WOMEN

Y N Are you taking birth control medication?
Y N Are you or could you be pregnant?
Y N Are you nursing?

Y N Are you taking any medications, pills or drugs?_____

Y N Are you under a physician's care now?Name_____Phone_____Fax_____

Y N I have had major surgery: Year_____Type of operation_____Year_____Type of operation_____

Y N Do you have any other medical problem or medical history NOT listed on this form?_____

Are you allergic to any of the following?

☐Aspirin ☐Codeine ☐Penicillin ☐Local Anesthetics ☐Latex ☐Metal ☐Other_____

PATIENT INTERVIEW

What are your thoughts about going to the dentist?_____

What were your previous dental experiences like? _____

What dental health problems have you had in the past?_____

Do you experience frequent headaches, neck, or back pain?_____

What do you like/dislike about your smile? _____

What are your objectives regarding your dental health? ☐Be Pain Free ☐Healthy Gums ☐Fresh Breath ☐Straighter teeth
☐Bright/White Smile ☐Keep your natural teeth for a life time ☐Handle the problem correctly the first time ☐Other_____

So that we may serve you personally and comfortably, which of the following are most important to you?

☐On time from start to finish
☐To be called after your visit to see how you are feeling
☐Ideal appointment times
☐To be done with treatment sooner with longer appointments
☐Shorter, more frequent appointment to complete treatment
☐To be informed of ways to enhance:
☐Facial appearance ☐Whiteness of teeth ☐Overall health
☐A clear understanding of the problems and prescribed solutions
☐A warm, moist towel after each visit
☐To handle only your most pressing needs
☐To know absolutely everything that is going on in your mouth, regardless of the severity
☐A call from our office to remind you of your exact date and time of your appointment
☐A call/reminder card from office to remind your preventative maintenance visits

CONSENT

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays may be deemed necessary and advisable by the doctor.

_____

Signature Date Relationship to Patient

HIPPA PRIVACY RULE PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of protected Health Information For Treatment, Payment, or Healthcare Operations (164.506(a))

I_____understand that as part of my healthcare, **Mountain View Dentistry** originates and maintains health records describing my health history, symptoms, examinations, diagnosis, test results, treatment and any plans for the future care and or treatment.

I am aware and acknowledge the **Notice of Privacy Practices** provided by **Mountain View Dentistry**. Upon request I may receive a copy of the **Notice of Privacy Practices.**

Patient Name_____Relationship_____

Signature_____Date_____

Parties to whom my Personal Health Information may be released:

_____

Name Relationship

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.
I understand that dental services furnished to me are charge directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. **I am aware there is a charge of $75.00 for any and all missed appointments without 24-hours notice.**

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. 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 and agree to their content.

_____

Signature Date

NOTICE OF INDEPENDENT CONTRACTORS

All doctors practicing at this facility are independent practices and are not employees of Shahab Ebrahimian Dental Group, INC. or Mountain View Dentistry, or any other dentist practicing at this location. As a courtesy and convenience to you, the independent contractor dentist(s) of your choice can access your dental records at Mountain View Dentistry. Using a single patient chart for your records can consolidate entries regarding your care by any of the independent dentists. If you have any dispute regarding payment and/or quality of care, please direct it to the attention of the treating doctor. By signing below you are agreeing to allow the dentist so named, to have access to your dental records at Mountain View Dentistry and allowing them to treat you. You are also agreeing to hold harmless Shahab Ebrahimian Dental Group, INC. or Mountain View Dentistry, and any independent contractor dentist practicing at Mountain View Dentistry who is not the dentist directly responsible for any disputed treatment or bill. Independent Contractors who may access your dental records at Mountain View Dentistry include:

Doctor Name	**Specialty**
Sean Ebrahimian, DDS	General Practice
Juliette Tamkin, DDS	General Practice

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Signature Date