

PATIENT HISTORY & INFORMATION

Soc. Security # _____

Date: _____

Driver's Lic. # _____

Birth Date: _____

NAME ^{MR.}_{MRS.}_{MS.} _____ LAST _____ FIRST _____ MIDDLE _____ Age: _____ Sex: _____ Marital Status: _____

ADDRESS (Home): _____ Phone: () _____
STREET CITY STATE/ZIP

ADDRESS (Bus.): _____ Phone: () _____
STREET CITY STATE/ZIP

Employer: _____ Occupation: _____

Nearest Relative in area: _____ Address: _____ Phone: () _____

Whom may we thank for referring you to this office? _____

PERSON RESPONSIBLE FOR PAYMENT -

Name: _____ Relationship: _____ Home Phone: () _____
Address: _____ City/State/Zip: _____ Work Phone: () _____

Social Security No.: _____ Employer: _____ Occupation: _____

Driver's License No.: _____ State and Expiration Date: _____

Bank and Branch: _____ Checking: _____ Savings: _____

Bill will be paid by: ☐ Self ☐ Insurance ☐ Other - Who: _____

Insurance company: _____ Policy No.: _____

In whose name is policy carried? _____ Insurance eligibility dates: _____ Medicare/Welfare No.: _____

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, or his nurse or qualified designate.

I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, **AT THE TIME OF SERVICE**, unless other arrangements are made with the Financial Department.

Signed _____
PATIENT, PARENT OR AGENT (MUST BE 18 YEARS OR OLDER)

MEDICAL/DENTAL HISTORY -

Physician's Name: _____ Address/City/State: _____ Phone: () _____

When did you last consult a physician? _____ Reason: _____

Have you been a patient in a hospital in the past 5 years: ☐ Yes ☐ No Reason: _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No

Name of former dentist: _____ Date of last dental examination: _____

Purpose of visit: ☐ complete examination ☐ pain ☐ broken tooth ☐ other Were Oral X-Rays taken? ☐ Yes ☐ No

Do you have, or have you had, any of the following? (Please check and describe fully under remarks):

	YES	NO		YES	NO		YES	NO
1. Heart Disease	☐	☐	12. Heart Attack	☐	☐	23. Allergies		
2. High Blood Pressure	☐	☐	13. Psychiatric Treatment	☐	☐	a. Penicillin	☐	☐
3. Blood disorder - anemia	☐	☐	14. Arthritis	☐	☐	b. Other Antibiotics	☐	☐
4. Rheumatic Fever	☐	☐	15. Tumor History	☐	☐	c. Codeine, Aspirin	☐	☐
5. Heart Murmur	☐	☐	16. Venereal Disease	☐	☐	d. Local Anesthetic, novocaine	☐	☐
6. Mitral Valve Prolapse	☐	☐	17. Sinus Trouble	☐	☐	e. Others	☐	☐
7. Thyroid disease, hyperthyroidism	☐	☐	18. Ulcers	☐	☐	24. Asthma	☐	☐
8. Diabetes	☐	☐	19. Radiation Treatment	☐	☐	25. Tuberculosis, Emphysema	☐	☐
9. Stroke	☐	☐	20. Liver or Kidney Disease	☐	☐	26. Do you smoke?	☐	☐
10. Epilepsy	☐	☐	21. Hepatitis (A, B, C), Jaundice	☐	☐	27. Are you pregnant?	☐	☐
11. Fainting	☐	☐	22. AIDS/HIV +	☐	☐	28. Headaches, neckaches, backaches?	☐	☐

Have you had excessive bleeding requiring treatment? ☐ Yes ☐ No

Are you taking any medicines, drugs, or pills (prescription or non-prescription)? ☐ Yes ☐ No

Have you experienced any unfavorable reaction to previous dental treatment? ☐ Yes ☐ No

Do you have any disease, condition, or problem not listed above that you think I should know about? _____

Remarks: _____

CARLSBAD ESTHETIC DENTISTRY

PATIENT NAME:

_____ **DATE:** _____

Please fill out the questionnaire before Dr. Yazdi comes in to do the examination of your mouth so we may better know your individual needs and wishes regarding dental treatment. Thank you.

- | | | | |
|-----|---|---|---|
| 1. | Would you like to improve your smile?
(more even teeth, whiter teeth?) | Y | N |
| 2. | Do you prefer fillings and crowns to look
like your own teeth (tooth-colored)? | Y | N |
| 3. | Are you interested in tooth whitening? | Y | N |
| 4. | Are you interested in a "Smile Makeover"? | Y | N |
| 5. | Do you grind or clench your teeth during the
day or night? | Y | N |
| 6. | Have you had past dental complications or
Problems? If yes, please explain. | Y | N |
| 7. | Are you aware of gum problems
(e.g. food collection, odor, bleeding)?
If yes, please explain. | Y | N |
| 8. | Do you take premedication for dental work?
Name of Medication _____ | Y | N |
| 9. | Have you had reactions to medications?
If yes, please explain. _____ | Y | N |
| 10. | What is your main dental concern? _____ | | |

Reviewed by Doctor: _____

OFFICE FINANCIAL AND INSURANCE POLICIES

CARLSBAD ESTHETIC DENTISTRY

MAHSAN YAZDI, DDS

Welcome to our office and thank you for selecting us to provide your dental care. Your dental insurance plan is to provide dental cost assistance while meeting a cost containment objective. Dental insurance plans have their particular limitations and exclusions. Some examples are: Oral reconstruction and smile makeovers, cosmetic dentistry, bonding, porcelain and composite on posterior teeth, whitening, attrition, erosions, and dentures, bridges or crowns where existing work can be functional by filling, repair, reline.

We attempt to try to estimate what insurance benefits **may** be available to each patient to better predict the out-of-pocket expense that may be expected after insurance benefits have been utilized. Estimates are not meant to be exact or absolute as we do not know for sure what insurance will cover or deny until claims have been filed and reviewed by the dental consultants with your insurance carrier. Coordination of dental insurance benefits can be confusing and difficult and we are very willing to act as an advocate to help our insured patients in securing all the benefits they are entitled to under their insurance policy.

Please initial each paragraph.

- 1) **INSURANCE DOES NOT GUARANTEE PAYMENT.** As a courtesy we will file claims to your insurance carrier for the primary insured for each visit to our office. We accept benefit assignments made by the insurance carriers to our office for treatment. Any claim not paid by insurance, for any reason, more than 30 days after filed is due and payable in full by the insured.
- 2) **CLAIM RE-FILEING.** Claims returned for incorrect information, requesting more documentation or any other reason will be handled as follows: a) the unpaid procedures on the claim will be due and payable by the insured to our office. We cannot wait for additional processing of the corrected/updated insurance claim to be paid. We will print a new insurance claim form on paper that can be obtained by the insured for self-filing. b) When we have the corrected information, we will, at the request of the insured, re-file the claim. The amount of the claim is still due and must be paid by the insured before we re-file. _____
- 3) **SECONDARY INSURANCE IS NOT ACCEPTED.** As a courtesy we will file a claim to the secondary insurance. We must receive all payments from the original claim filed to primary and any unpaid balance from the insured before we file with the secondary insurance carrier. Payments from the secondary insurance will be directed to the patient. Some secondary insurance does not apply. _____
- 4) **PATIENT CO-PAYMENTS.** Dental plans require co-payments for certain procedures, and payments are due IN FULL and payable BEFORE the procedure begins. We accept payment by Visa, Master, Discover, cash and check (UP TO \$500). Financing options are available; please ask the treatment coordinator about your options. There is a \$25.00 processing charge for all returned checks. _____
- 5) **CANCELATION POLICY.** Office policy requires 48 hours advance notice to cancel an appointment. There is a \$100.00 charge for less than 48 hours notice when canceling an appointment. Our office reserves the right to transfer patients out of this office for failure to comply with your plan guidelines including failed appointments. This may affect all those insured under the same plans _____.
- 6) **Our practice focuses on one-one personalized service, quality care and attention to detail. To do so, we must ensure that we allow enough time for each patient's appointment. With this in mind, for all treatments requiring longer than one hour appointment, we require indication of commitment by 50% deposit at the time of scheduling _____.**

I understand and consent to the above information.

PATIENT SIGNATURE

DATE