

Camelia Espahbod DDS MSD
Comprehensive Family and Cosmetic Dentistry

For Office Use Only:

Personal Information

Patient Name: _____
Last First MI Preferred

Gender: Male _____ Female _____ Marital Status: _____

Social Security #: _____ Birthdate: _____

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____

Address _____
Street Apartment/Suite #

City State Zip

Emergency Contact: _____ Relationship: _____

Phone #: _____

Referral Information

Who can we thank for referring you? _____ Other: _____

Health History

Welcome to our office. We appreciate your confidence in allowing us to provide you dental care. Correct answers to the following questions will help us to provide the appropriate care. This information is confidential. Any omissions or incorrect information could compromise care and lead to serious complications. If you have questions, please ask for clarification.

Name of your medical doctor: _____ Phone : _____

Date of last physical: _____

1. Have there been any changes in your general health in the last year? _____

2. Have you had any serious illnesses, operations or hospitalizations? Yes _____ No _____

If yes, please describe including dates: _____

Medical Health

Yes No

Do you require antibiotic premedication for dental treatment?

Do you have , or have you had, any of the following?

Heart	Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
If yes , what year? _____		

Other (cont.)	Yes	No
Do you smoke or chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much daily? _____		
If you have quit smoking or chewing tobacco,		
how long has it been since you quit	_____ Yrs	_____ Months
how long did you use tobacco	_____ Yrs	_____ Months

Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker Installed	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Problem	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type and when? _____		

Immune	Yes	No
Recurring Infection of any kind	<input type="checkbox"/>	<input type="checkbox"/>
Any disease, drugs, or transplant operations that may suppress your immune system	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic, or have you reacted adversely, to any of the following:

	Yes	No
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam	<input type="checkbox"/>	<input type="checkbox"/>
Other: please list _____	<input type="checkbox"/>	<input type="checkbox"/>

Blood	Yes	No
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>

Bone or Joint	Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement (hip, knee etc.)	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when? _____		

Please list any prescription medications you are now taking.

Other	Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A , B or C	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers or Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer of any kind	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type? _____		

Please list any non-prescription medications (over the counter).

This includes herbal medication, weight gain or loss drugs, drugs to enhance athletic performance and street drugs.

Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how much? _____		

Women	Yes	No
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, delivery date _____		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Are you using birth control medication?	<input type="checkbox"/>	<input type="checkbox"/>

Dental Health

Please answer the following questions by checking the appropriate box;

	Yes	No
Are you apprehensive about dental treatment	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Where: _____		
Do you avoid brushing any part of your mouth because of pain	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth	<input type="checkbox"/>	<input type="checkbox"/>
Which side: _____		
Do your gums bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent or recurring mouth sores	<input type="checkbox"/>	<input type="checkbox"/>
So you get "Cold Sores" around your lips	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:		
Cold food or Liquids	<input type="checkbox"/>	<input type="checkbox"/>
Hot food or liquids	<input type="checkbox"/>	<input type="checkbox"/>
Sweets	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Do you like the color of your teeth	<input type="checkbox"/>	<input type="checkbox"/>
If not, are you interested in whitening your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Do you like the shape of your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Do you like the position of your teeth	<input type="checkbox"/>	<input type="checkbox"/>
If not, are you interested in orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>
Do you catch yourself clenching your jaws frequently during the day	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel like you clench or grind your jaw while sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw feel tired during the day or at night	<input type="checkbox"/>	<input type="checkbox"/>
Has your jaw ever locked so you couldn't open or close freely	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw hurt when you chew or open wide	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as wide as you want	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that your bite is changing	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up in the morning with a headache	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an earache or pain in front of the ears	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been in a car accident	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum-chewer or pipe-smoker	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with temporomandibular disorder (TMJ problems)	<input type="checkbox"/>	<input type="checkbox"/>

How often do you brush? 1 x a day 2 x a day 3 x a day Other _____

What kind of toothbrush do you use?

Manual	<input type="checkbox"/>
Battery operated	<input type="checkbox"/>
Electrical (Sonicare etc.)	<input type="checkbox"/>

How often do you floss? 1 x a day 2 x a day 3 x a day Other _____

Insurance Information

Primary Insurance Plan Name: _____

Subscriber's Name: _____

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Employer Name: _____

Patient's relationship to Subscriber: Self Spouse Child Other _____

Secondary Insurance Plan Name: _____

Subscriber's Name: _____

Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Employer Name: _____

Patient's relationship to Subscriber: Self Spouse Child Other _____

Financial Policy

Patient's who carry dental insurance understand that all dental services furnished are charged directly to the patient and that **he or she is personally responsible for payment of all services rendered.** This office will help prepare the insurance forms and assist in making collections from the insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

PAYMENT OPTIONS

1. CARE CREDIT

Payment plans up to 60 months
Fast, confidential service by phone, 1-800-677-0718. Or on-line at
www.carecredit.com

2. OFFICE PAYMENT PLAN

Balance of account due 90 days after completion of treatment.
3 monthly payments.

3. PAYMENT IN FULL AT TIME OF SERVICE

Cash, Check or all major Credit Cards Accepted
(A discount of 5% on cash or check payments is given for direct payment of treatment at the time of service)
(5% discount is not applicable with senior discount or patient's with dental insurance)

Authorization and Release

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

To avoid a \$75.00 charge per hour, we request, as a courtesy, 2-business days notice for appointment cancellation or rescheduling. For example, if your appointment is on a following Monday, we request that you call us by Thursday.

I certify that all of the information above has been read and understood by me. I have answered all questions accurately and understand that incorrect information could adversely affect my health. I understand that my dental insurance is a benefit to me from my employer, and while the office is happy to assist me with billing for my dental services, I am ultimately responsible for payment of my account within 30 days regardless of insurance participation. I agree to these stipulations on my own behalf and any dependants who receive treatment at this office. I assign Insurance Benefits to the Provider. **I also acknowledge that HIPPA Notice of Privacy Practices are available to me upon request.**

Signature of patient, parent or guardian: _____ Date: _____

Signature of Responsible Party: _____ Date: _____