GENTLE DENTAL

1 PATIENT INFORMATION (confidential)

Date _____

Patient _____ SS#_____ ☐ Male ☐ Female

Birthdate _____/_____/_____/ Age _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____ City _____ State _____ Zip _____

Home ( ) _____ Work ( ) _____ ext._____ Cell. ( )_____

Email Address _____ Driver License #_____

Patient's Employer _____

Business Address _____ City _____State _____ Zip _____

Spouse's Name _____ Cell Phone _____ Work Phone _____

Person Contact in Case of Emergency _____ Phone _____

Whom May We Thank for Referring You? _____

2 *Responsible Party (if other than yourself)*

Name of Responsible Party _____ Relationship to Patient _____

Home Phone _____ Birthdate _____ SS# _____

Address _____City _____ State _____ Zip _____

Employer _____ Work Phone _____

Is this Person currently a patient in our office? ☐ Yes ☐ No Driver's License # _____

3 *Dental Insurance Information*

Policy Holder Name _____ Relation to Patient _____

Birthdate _____ SS# _____

Employer _____

Insurance Company _____ Group _____ Policy ID#_____

Ins. Co. Phone# _____

I, the undersigned certify that I (or my dependent) have insurance with _____and assign directly to Dr. Hameed Farrokhrooz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature Date

4 DENTAL HISTORY

Reason for today's visit_____

_____

Former Dentist _____

City/State _____

Previous Dental Problems_____

_____

Date of last dental visit _____

Date of last X-rays _____

Place a Mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ☐ Yes ☐ No

Bleeding gums ☐ Yes ☐ No

Blisters on lips or mouth ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No

Chew on one side of mouth ☐ Yes ☐ No

Cigarette, pipe, or cigar smoking ☐ Yes ☐ No

Clicking or popping jaw ☐ Yes ☐ No

Dry mouth ☐ Yes ☐ No

Do you grind your teeth ☐ Yes ☐ No

Do you routinely take Analgesics? (Aspirin, Tylenol, Motrin.) ☐ Yes ☐ No

Food collection between the teeth ☐ Yes ☐ No

Grinding teeth ☐ Yes ☐ No

Gums swollen or tender ☐ Yes ☐ No

Jaw pain or tiredness ☐ Yes ☐ No

Lip or cheek biting ☐ Yes ☐ No

Loose teeth or broken fillings ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Orthodontic treatment ☐ Yes ☐ No

Pain around ear ☐ Yes ☐ No

Periodontal treatment ☐ Yes ☐ No

Sensitivity to cold ☐ Yes ☐ No

Sensitivity to heat ☐ Yes ☐ No

Sensitivity to sweets ☐ Yes ☐ No

Sensitivity when biting ☐ Yes ☐ No

Sores or growths in your mouth ☐ Yes ☐ No

Worn teeth ☐ Yes ☐ No

How often do you floss? _____

How often do you brush? _____

Would you like whiter teeth? ☐ Yes ☐ No

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on"yes" or "no" to indicate if you have had any of the following:

Acid Reflux/GERD	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Headaches, Migraine	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Headaches, Behind the eye	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Headaches, Chronic	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches, Morning	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints, Pins, Metal	☐ Yes ☐ No	Headaches, Sinus	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Headaches, Tension	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Bleeding abnormally, with		Heart Problems	☐ Yes ☐ No	Snore	☐ Yes ☐ No
extractions or surgery	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stiff/Sore/Painful Jaw	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stiff/Sore Neck	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Hospitalized	☐ Yes ☐ No	Surgery	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cough, persistent or		Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on	
bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	head or neck	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss,	
Fainting or dizziness	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	unexplained	☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Woman:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any Medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____)_____

ALLERGIES

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____
☐ None

Authorization and Release

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and / or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

Signature of patient (or parent if minor)

WELCOME TO OUR PRACTICE

We are genuinely pleased that you have chosen us for your dental care. We will do our best to continue to earn your confidence. Our staff is dedicated to providing you with the most comfortable and technically up-to-date dental care.

We ask that you make every effort to keep your appointments. Missing an appointment disrupts proper sequencing of care and delays completion of your treatment. If you need to reschedule your appointment, please call us at least 24 hours prior to your visit. (Monday would have to be changed by Friday 12:00 pm) Arriving late is sometimes unavoidable, therefore our policy is: If the patient arrives more than 10 minutes late, we will evaluate our schedule to determine if the patient can be seen. In some instances the patient may be asked to reschedule. A broken appointment will be charged at a rate of $85.00 per hour. Should a patient continue to break appointments, we reserve the right to dismiss that patient from the practice.

We will file your insurance for you as a courtesy. Please remember that we have no control over the benefits of your plan, you are the one who chose your insurance and it is your responsibility to be aware of what your benefits are.

If there is an unpaid balance on your account, you will receive a billing letter allowing you 10 working days to pay; at that time if we have not received your payment your card provided below will be debited. I understand that any portion of the estimated amount not paid by my insurance and claims not paid within 60 days will be my responsibility.

1. I choose to have my insurance company pay their portion to your office. I wish to put any unpaid balance on my Credit/Debit Card.
Credit/Debit Card # _____ Exp Date: _____
Signature Panel 3 Digits on back of card (CID) _____

2. I choose to pay the entire fee myself at the time services are rendered and submit my own claims for reimbursement.

PLEASE SIGN BELOW -- I HAVE READ AND UNDERSTAND THE POLICIES.

_____ _____
Print Name **Date**

_____
Signature

PATIENT CONSENT FORM (HIPPA)

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 (HIPPA). 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 Notices of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. 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 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 operations, but that you are not required to agree to these requested restrictions. However, if you do not 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 this date I revoke this consent is not affected.

Signed this _____ day of _____, 20___

Print Patient Name_____

Relationship to Patient:_____

Signature:_____