Hedy Atashbar, D.D.S.

Patient Information

Patient Name: _____ **Preferred Name:** _____
First M Last

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other_____

Birth Date: ___/____/_____ **Social Security#:** _____-____- _____ **Driver License#:** _____

Phone# (Home): _____ **(Work):** _____ **ext:** _____ **(Mobile):** _____

E-Mail: _____

Address:_____
Street *Apartment #*

_____
City State Zip Code

In case of an emergency, contact: _____ **Relationship:** _____ **Phone:** _____

Referral Information

☐ Patient ☐ Relative ☐ Specialist Office ☐ Insurance ☐ Internet ☐ School ☐ Work ☐ Other

Name of person or office referring you to our practice:_____

Health Information

Date of Last Dental Visit: _____ Reason for seeing Dr. Atashbar today:_____

Have you ever had any of the following? (PLEASE CIRCLE Y for YES OR N for NO)

Y N HIV/AIDS	Y N Glaucoma	Y N Pacemaker	Y N Venereal Disease
Y N Allergies	Y N Growths	Y N Currently Pregnant	Y N HPV
Y N Anemia	Y N Hay Fever	Due Date: _____	Y N Codeine Allergy
Y N Arthritis	Y N Head Injuries	Y N Radiation Treatment	Y N Penicillin Allergy
Y N Artificial Joints	Y N Heart Disease	Y N Respiratory Problems	Y N Tetracycline Allergy
Y N Asthma	Y N Heart Murmur	Y N Rheumatic Fever	Y N Nitrous Allergy
Y N Blood Disease	Y N Hepatitis (A,B,C,D,E)	Y N Rheumatism	Y N Latex Allergy
Y N Cancer	Y N High Blood Pressure	Y N Sinus Problems	Y N Sulfa Allergy
Y N Diabetes	Y N Jaundice	Y N Stomach Problems	Y N Aspirin Allergy
Y N Dizziness	Y N Kidney Disease	Y N Stroke	Y N Local Anesthetic Allergy
Y N Epilepsy	Y N Liver Disease	Y N Tuberculosis	OTHER Allergies:
Y N Emphysema	Y N Mental Disorders	Y N Thyroid	☐ _____
Y N Excessive Bleeding	Y N MitralValveProlapse	Y N Tumors	Y N Flu
Y N Fainting	Y N Nervous Disorders	Y N Ulcers	Y N Drug/Alcohol Abuse

- Do you need to pre-medicate with antibiotics prior to dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you currently taking any medications: (please list) _____
- Are you taking BISPHOSPONATE medications (Fosamax, Boniva, Aredia, etc.)? ☐ 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

Name of Physician: _____ Phone: _____ If yes, please explain: _____

- Do you have any health problems that need further clarification with your Physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you smoke or use tobacco products? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding 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.

X_____ X_____
Signature of patient, parent, or guardian **Today's date**

_____
Doctor's Signature

---- OVER ----

Employment Information (Required)

Employer's Name: _____ Occupation: _____
Address:_____
Street City State Zip Code

Insurance Information (Required)

Subscriber of Insurance_____ Relationship to patient _____
Insurance Co. Name _____ Telephone Number _____
Contract ID#/Subscriber ID# _____ Group # _____ Employer's Name _____
Insurance Address _____ City _____ State _____ Zip _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE ☐ YES ☐ NO

Subscriber of Insurance _____ Relationship to patient _____
Insurance Co. Name _____ Telephone Number _____
Contract ID#/Subscriber ID# _____ Group # _____ Employer's Name
_____
Insurance Address _____ City _____ State _____ Zip _____

Responsible Party Information (Required)(Person Responsible for Payment)

Name _____ Relationship to patient _____
Social Security # _____ Birth Date _____ Phone (home) _____(work) _____
Address_____
Street City State Zip Code

PATIENT TREATMENT CONSENT

I authorize the Dentist or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist and mutually agreed upon by me.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes this Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation **"SIGNATURE ON FILE"**. I authorize my Dentist to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 45 days from the date of treatment might be assessed to a service charge and/or turned over to a collection agency. I am aware that if my account is turned over to a collection agency, I will be responsible to pay 25% collection agency fees and/or $50.00 court costs or attorney fees.

I have read the above conditions of treatment and payment and agree to their content.

Patient Name (Please Print) _____
Signature of patient, parent or guardian: _____(SEAL) Date: _____

The interested parties may revoke this authorization in writing only.
Please note once records are established there is a $35.00 charge for duplication of records including x-rays.
Charges will apply for missed or canceled appointments without proper notification.