

Welcome!

Patient's Full Name _____ Date of Birth _____

Nickname, if any _____ Social Security # _____

Male Female Single/Divorced/Widowed Married/Partnered Minor

Address _____ Home Phone () _____

City/State/Zip _____ Work Phone () _____

Email _____ Cell Phone () _____

Spouse Name (or Parent, if patient is a minor child) _____

Work Phone () _____ Cell Phone () _____

Whom to notify in case of emergency? _____

Daytime Phone () _____

Other family members in this practice _____

Whom may we thank for referring you to our practice? _____

RECEIPT OF PUBLICATIONS

I acknowledge receipt of the Privacy Statement, Dental Materials Fact Sheet, and Infection Control protocol, either separately or as part of a new patient packet. I understand that it is my responsibility to read and understand this information, and that I may request clarification from the dental office for any materials I do not understand.

Patient/Guardian Signature _____ Date _____

PATIENT INFORMATION

Patient's Name _____

Date of Birth _____

Are you currently under the care of a physician?

Physician's Name _____

Phone _____

Address _____

When was your last complete physical exam? _____

Please list any MEDICATIONS or health –related substances you currently or routinely take:

Please list all ALLERGIES you have (including medications, substances, penicillin, antibiotics, anesthetics, metals or latex):

Women: Are you currently taking birth control medication?

Yes No

Women: Are you pregnant or suspect you might be pregnant?

Yes No

Please check any of the following conditions that you now have or have had in the past:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Artificial Heart Valve Implant | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Artificial Joints/Prosthesis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Inflammatory Disease (arthritis, etc.) | <input type="checkbox"/> Blood Disorder (anemia, leukemia, etc.) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cancer |

Please list any disease, condition or problem not listed above: _____

Please name any surgeries you have had: _____

Have you ever had radiation treatment or chemotherapy for tumor, growth or other condition? Yes No

Do you smoke, chew, use snuff or any other forms of tobacco? Yes No

Do you consume alcoholic beverages? Yes No

Do you habitually use controlled substances? Yes No

Have you received psychiatric treatment? Yes No

Have you taken fenfluramine, fenfluramine-phentermine (fen-phen), dexfenfluramine (redux) or other weight loss drugs? Yes No

Is there anything you would like to speak to the doctor about privately? Yes No

I certify that the above information is complete and accurate.

Patient/Guardian's Signature _____

Date _____

Dentist's Signature _____

Date _____

MEDICAL HISTORY

Patient's Full Name _____

Date of Birth _____

DENTAL INSURANCE – Primary (1st) Coverage

Employee Name _____

Date of Birth _____ SS # _____

Employer _____

Insurance Co. _____

Claims Address _____

City, State, Zip _____

Phone _____ Group # _____

I understand that I am financially responsible for payment in full for this account. I hereby authorize payment of insurance benefits directly to Ronald S. Sinanian, DDS, which would otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that the difference may be my responsibility.

Signature _____ Date _____

DENTAL INSURANCE – Secondary (2nd) Coverage

Employee Name _____

Date of Birth _____ SS # _____

Employer _____

Insurance Co. _____

Claims Address _____

City, State, Zip _____

Phone _____ Group # _____

I understand that I am financially responsible for payment in full for this account. I hereby authorize payment of insurance benefits directly to Ronald S. Sinanian, DDS, which would otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that the difference may be my responsibility.

Signature _____ Date _____

PAYMENT POLICY

Payment is due in full at the time services are rendered.

For the convenience of our patients who have dental insurance, we are happy to bill your insurance carrier directly; however, we reserve the right to require payment in full from you and to have your insurance company reimburse you.

We also reserve the right to charge you for missed appointments and/or appointments cancelled less than 24 hours in advance of scheduled time.

Payments may be made by cash, check, Visa, MasterCard or CareCredit.

A \$50 returned check fee will apply for non-payment due to insufficient funds.

Payments not received when due may result in your account accruing interest at a rate of 21% and/or in your account being turned over to an agency for collection.

I UNDERSTAND AND AGREE TO THE TERMS LISTED ABOVE.

Signature _____

Date _____

ACCOUNT INFORMATION