New Patient Information

Patient Name : _____ Date : _____
Last First MI

Gender: _____ Family Status: Married _____ Single _____ Child _____ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ Work: _____ Ext: _____ Mobile: _____

Best time to call: _____ May we call you at Work: Yes ☐ No ☐ Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

In case of emergency, who would you like us to contact?

Name: _____ Relationship: _____ Number: _____

Who may we thank for referring you to our office?

Friend/family member Another Dentist/Dental office _____ Staff member _____

How did you hear about our dental office? Google _____ Our Website _____ Social Media _____

What is the reason for your visit today? _____

What, if anything would you like to change about your smile? _____

Have you ever had any complications with or 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: _____

Name of Primary Care Physician: _____ Phone: _____

I would like to know more about: ____ Whitening ____ TMJ Treatment ____ Invisalign

____ Electric Toothbrushes ____ Facial Botox ____ Other

Responsible Party Information

☐ Self (skip to employment section below) ☐ Parent or Guardian

Name: _____
Last First MI

Gender _____ Family Status: Married ____ Single ____ Child ____ Other ____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ Work: _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Responsible Party Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Phone: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Address: _____
Street City State Zip Code

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Address: _____
Street City State Zip Code

Health Information

Please mark (☑) your response to indicate if you have had any of the following:

☐ AIDS+/HIV
☐ Anemia
☐ Artificial Joints (Date: _____)
☐ Asthma
☐ Cancer
☐ Chemotherapy
(Date of last treatment: _____)
☐ Diabetes (Type 1 / Type 2)
☐ Difficulty Breathing
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Fever Blisters/Herpes
☐ Head Injuries
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Heart Surgery
☐ Hepatitis A / B / C

☐ High Blood Pressure

☐ Jaw Pain (TMJ/TMD)

☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorder
☐ Mitral Valve Prolapse
☐ Nervous / Anxiety Disorder
☐ Pacemaker

☐ Parkinson Disease
☐ Are you pregnant? (Due date: _____)
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Sexually Transmitted Disease
☐ Sinus Problem
☐ Stomach Problem
☐ Stroke
☐ Thyroid Problem (Hyper/Hypo)
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ History of Narcotic Use
What type _____ Frequency _____
☐ History of Alcohol Use
Frequency _____
☐ History of Tobacco Use
Frequency _____
☐ Other Conditions:
_____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Do you have any allergies to food, medication, latex, etc.?

☐ Latex ☐ Penicillin/Amoxicillin ☐ Clindamycin ☐ Metals (Nickel, Titanium)

Other allergies: _____

Are you currently taking any medications (including over the counter vitamins, herbal supplements, etc.? Please list:

_____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Patient name (printed): _____ Patient Signature: _____

Parent/Guardian signature if minor _____ Date: _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ DOB: ____/____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to whom?

Please write first and last name:

☐ Spouse _____

☐ Child(ren) _____

☐ Others _____

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell Number: _____

The best time to reach me is (day) _____ between (time) _____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ _____

Signed: _____ Date: ____/ ____/ _____

Witness: _____ Date: ____/ ____/ _____

Financial Agreement

As a condition of your treatment by this office, payment for dental service are due in full, at any time treatment is rendered. Any other financial arrangements must be made in advance. Patients are responsible for the costs incurred for their dental care and assume all financial responsibility.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or with a credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services provided are charged directly to the patient and that he/she is personally responsible for payment of all dental services. Our office will help prepare insurance claims or assist in filing to the insurance companies as a courtesy. However, this dental office cannot render services on the assumption that our fees will be paid by your insurance company. Insurance coverage is an agreement/contract between the patient and the insurance company.

I authorize and agree to the use of my signature below for use on all insurance submissions.

I understand that the fee estimate for this dental treatment can only be extended for a period of three months from the date of the patient examination.

I understand that every appointment is scheduled for my exclusive needs. Therefore, I agree to give Dr. Karimi's office a minimum of 24 hours' notice if I am unable to keep a scheduled appointment. I understand that there is a fee of $60.00 (per hour) for any failed or missed appointments.

In consideration, for the services rendered to me, I agree to pay the fee for these services to Karimi DDS, or his assignee, at the time services are rendered. I further agree to pay all costs and fees related to a collection agency and/or attorney's fee if utilized.

I grant my permission to Dr. Karimi, or their assignee, to telephone me at home or at my work to discuss matters related to my dental treatment or financial arrangement for my dental treatment.

I have read the above conditions of dental treatment and payment, and I agree with all conditions.

Patient name: _____ Patient signature: _____

Parent/guardian: _____ Parent/guardian signature: _____

Witness signature: _____ Date: _____