



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 _____	Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Dental Problems _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last X-rays _____	Do you grind your teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a Mark on "yes" or "no" to indicate if you have had any of the following:	Do you routinely take Analgesics? (Aspirin, Tylenol, Motrin.) <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Worn teeth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like whiter teeth? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches, Migraine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches, Behind the eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches, Chronic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches, Morning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints, Pins, Metal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches, Sinus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches, Tension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Snore	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stiff/Sore/Painful Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stiff/Sore Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> 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 (_____) _____

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	
	<input type="checkbox"/> None

ALLERGIES

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 _____
Signature of patient (or parent if minor)

_____ Date

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: _____