ADVANTAGE DENTAL CARE

Dr. Nader Zanzi DMD   Dr. Raj Zanzi DMD
6910 Douglas Blvd. Ste F Granite Bay, CA 95746
(916) 780-7676

We are pleased to welcome you to our practice. Please take few minutes to fill out this form as completely as you can. If you have questions we`ll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name____**Soc. Sec#**________________________
Last Name *First Name* *Initial*
Address____ **City**_______________________________

State________**Zip**____________**Email**____________________________________**Sex** □ **M** □ **F** **Age** ___________

Home Phone____________________ **Cell Phone** _____________________**Work Phone**___________________

Birth date _____________________ □ **Single** □ **Married** □ **Widowed** □ **Separated** □ **Divorced**

Patient Employed by_____________________________________**Occupation**__________________________

Business Address ____**Business Phone**__________________

Whom may we thank for referring you? ____

Notify in case of emergency ____ **Phone**_____________________

Primary Insurance

Person Responsible for Account____

Relation to Patient _______________________ **Birth date** _______________**Soc. Sec#**_____________________

Address (if different from patient) ____

City________________________________**State**_________**Zip**____________ **Home Phone**__________________

Responsible Party Employed by______________________________**Occupation**_________________________

Business Address ____**Business Phone**_____________________

Insurance Company _______________________ **Phone #**____________________ **Group #**__________________

Subscriber #_________________ **Name of other dependents under this plan**______________________________

Additional Insurance

Is the patient covered under additional insurance? □**Yes** □ **No**

Subscriber Name________________________ **Relation to patient** _______________ **Birth date**______________

Address (if different from patient) _____________________________________**Soc. Sec #**___________________

City________________________________**State**_________**Zip**____________ **Home Phone**__________________

Subscriber Employed by _______________________________________**Business Phone**____________________

Insurance Company____**Phone #**___________________________

Group #____________________**Subscriber #**______________________________

Dental and Medical History

Patient Name: ______________________________ DOB: ______________

What would you like us to accomplish today? ______________________Are you in pain? __________

Former Dentist________________ Address______________________________

Dentist Email______________________________Phone____________________

Date of last dental care____________________Date of your last X-rays____________________

Circle yes or no if you have had problems with any of the following:

Are any of your teeth sensitive to:	**How are your gums?**	**Do you:**
Hot or cold? **YES NO**	Do they bleed or hurt? **YES NO**	Clench or grind teeth awake or sleep? **YES NO**
Sweets? **YES NO**	Parents experience with gum disease? **YES NO**	Bite cheeks or lips? **YES NO**
Biting or chewing? **YES NO**	Noticed any loose teeth? **YES NO**	Snore or have sleeping disorder? **YES NO**
Noticed any mouth odors? Bad taste? **YES NO**	Does food get caught between teeth? **YES NO**	**Have you experienced:**
Do you get cold sores blisters? **YES NO**	If yes where?______________	Clicking or popping jaw? **YES NO**
Have you ever had:	How often do you brush? ______________	Pain?(joint, ear, side of face) **YES NO**
Orthodontic treatment? **YES NO**	How often do you floss? ______________	Difficulty in opening or closing the mouth? **YES NO**
Oral Surgery? **YES NO**	What would you like to change about your smile? ______________ ______________	Headaches, neck-aches or shoulder aches? **YES NO**
Periodontal Treatment? **YES NO**		Tired jaws in the morning? **YES NO**
Your teeth ground or bite adjustment? **YES NO**		
A bite plate or mouth guard? **YES NO**		
A serious injury to mouth or head? **YES NO**		
If so, please describe: ______________		

Physician's name ____________________ Phone __________ Date of last visit____________

Have you had a serious illness or operations **YES NO** If yes, describe ______________________

Are you currently under physician care? **YES NO** If yes, Describe______________________

Have you ever taken Fen-Phen/Redux? **YES NO** **Women**: Are your pregnant? **YES NO** Nursing? **YES NO** Taking birth control? **YES NO**

If you have or had any of the following please Circle, Yes or No:

YES NO AIDS/HIV positive	**YES NO** cortisone treatment	**YES NO** herpes	**YES NO** scarlet fever
YES NO anaphylaxis shock	**YES NO** cough, persistent	**YES NO** hepatitis	**YES NO** shingles
YES NO anemia	**YES NO** cough up blood	**YES NO** high blood pressure	**YES NO** shortness of breath
YES NO arthritis	**YES NO** diabetes	**YES NO** jaw pain	**YES NO** skin rash
YES NO artificial heart valves	**YES NO** epilepsy	**YES NO** kidney disease	**YES NO** spina bifida
YES NO artificial joints	**YES NO** fainting	**YES NO** liver disease	**YES NO** stroke
YES NO asthma	**YES NO** food allergies	**YES NO** material allergies	**YES NO** surgical implant
YES NO allergy prone	**YES NO** glaucoma	**YES NO** mitral valve prolapse	**YES NO** swelling feet
YES NO back problems	**YES NO** headaches	**YES NO** pacemaker	**YES NO** thyroid disease
YES NO blood disease	**YES NO** heart murmur	**YES NO** psychiatric care	**YES NO** tobacco habit
YES NO cancer	**YES NO** heart problems	**YES NO** rapid weight change	**YES NO** tonsillitis
YES NO Chemical depend.	Describe__________	**YES NO** radiation treatment	**YES NO** tuberculosis
YES NO Chemotherapy	**YES NO** hemophilia	**YES NO** respiratory disease	**YES NO** Ulcer/colitis
YES NO circulatory problem			**YES NO** venereal disease

MEDICATIONS:	**ALLERGIES:**	
List medications:______________	Aspirin	Local Anesthesia
______________	Sleeping pills	Penicillin
______________	Codeine	Sulfa
Pharmacy name:______________	Iodine	Other: ______________
Phone:______________	Latex	______________

Patient/ Guardian Signature:______________ Date:__________

Doctor Signature:______________

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OFFICE POLICY

FINANCIAL POLICY
Estimated patient portions are due when services are rendered. We accept cash, check, Visa, MasterCard, Discover and Care Credit.

INSURANCE
We will bill your insurance as a courtesy to you. It is important to provide us with current information. Your policy is a contract between you and your insurance company; we are not party to that agreement. Insurance policies vary, and **it is the patient's responsibility to know what is covered,** their yearly maximum and what is left for the contractual year. Some services provided may not be a covered benefit. We cannot exceed the insurance allowance.

MINORS
Treatment of minors cannot be performed without a parent or guardian accompanying the minor.

MISSED APPOINTMENTS
Be advised that the policy of this office is to charge a failed appointment fee of **$65.00** per hour, with a one hour minimum for any appointment failed or cancelled without **two business days notice.** Our office hours are Monday 8:00 AM – 5:00 PM, Tuesday 8:00 AM – 5:00 PM, Wednesday 9:00 AM - 6:00 PM, Thursday 8:00 AM to 1:00 PM and Friday 8:30 AM – 5:00 PM.

SERVICE CHARGE
All accounts 60 days or greater past due will be subject to 18% interest rate. Fees incurred to collect payment will be billed to and payable by the patient or responsible party. There is a charge of **$25.00** for all returned checks.

FINANCIAL CONSENT
The patient/ guardian agree to be fully responsible for fees acquired in this office.

I Understand and Agree To This Policy and Agreement.

Signature: ____ Date: __________________

DENTAL MATERIAL FACT SHEET

I have received a copy of the dental materials fact sheet as required by law.

Signature: ____ Date: ___________________

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED PERSONAL HEALTH INFORMATION AS IN ACCORDANCE WITH THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNABILITY ACT (HIPAA), EFFECTIVE APRIL 14,2003

With my consent **Advantage Dental Care**, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care options (TPO). Please refer to **Advantage Dental Care** Notice of Privacy Practices for more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Advantage Dental Care** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Practices may be obtained by calling the office at the phone number listed above. A copy will be sent to you in a reasonable amount of time.

With my consent, **Advantage Dental Care** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and health care operations.

With my consent, **Advantage Dental Care** may send patient statements and reminder cards to my home or any other designated location. **Advantage Dental Care** may post the daily schedule, in designated areas to assist the staff in carrying out dental treatment. I have the right to request that **Advantage Dental Care** restrict how it uses or discloses my PHI to carry out health care and business operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by that agreement.

By signing this form, I am consenting to **Advantage Dental Care** use and disclosure of my PHI and treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Advantage Dental Care** may decline to provide dental treatment to me.

______________________________	______________________________	________
Signature of Patient or Legal Guardian	Print Name of Patient or Legal Guardian	Date