

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:

<p style="text-align: center;">Are any of your teeth sensitive to:</p> <p>Hot or cold? YES NO Sweets? YES NO Biting or chewing? YES NO Noticed any mouth odors? Bad taste? YES NO Do you get cold sores blisters? YES NO</p> <p style="text-align: center;">Have you ever had:</p> <p>Orthodontic treatment? YES NO Oral Surgery? YES NO Periodontal Treatment? 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: _____</p>	<p style="text-align: center;">How are your gums?</p> <p>Do they bleed or hurt? YES NO Parents experience with gum disease? YES NO Noticed any loose teeth? YES NO Does food get caught between teeth? YES NO If yes where? _____</p> <p style="text-align: center;">How often do you brush? _____</p> <p style="text-align: center;">How often do you floss? _____</p> <p>What would you like to change about your smile? _____ _____</p>	<p style="text-align: center;">Do you:</p> <p>Clench or grind teeth awake or sleep? YES NO Bite cheeks or lips? YES NO Snore or have sleeping disorder? YES NO</p> <p style="text-align: center;">Have you experienced:</p> <p>Clicking or popping jaw? YES NO Pain?(joint, ear, side of face) YES NO Difficulty in opening or closing the mouth? YES NO Headaches, neck-aches or shoulder aches? YES NO Tired jaws in the morning? YES NO</p>
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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 you 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:

<p>YES NO AIDS/HIV positive YES NO anaphylaxis shock YES NO anemia YES NO arthritis YES NO artificial heart valves YES NO artificial joints YES NO asthma YES NO allergy prone YES NO back problems YES NO blood disease YES NO cancer YES NO Chemical depend. YES NO Chemotherapy YES NO circulatory problem</p>	<p>YES NO cortisone treatment YES NO cough, persistent YES NO cough up blood YES NO diabetes YES NO epilepsy YES NO fainting YES NO food allergies YES NO glaucoma YES NO headaches YES NO heart murmur YES NO heart problems Describe _____ YES NO hemophilia</p>	<p>YES NO herpes YES NO hepatitis YES NO high blood pressure YES NO jaw pain YES NO kidney disease YES NO liver disease YES NO material allergies YES NO mitral valve prolapse YES NO pacemaker YES NO psychiatric care YES NO rapid weight change YES NO radiation treatment YES NO respiratory disease</p>	<p>YES NO scarlet fever YES NO shingles YES NO shortness of breath YES NO skin rash YES NO spina bifida YES NO stroke YES NO surgical implant YES NO swelling feet YES NO thyroid disease YES NO tobacco habit YES NO tonsillitis YES NO tuberculosis YES NO Ulcer/colitis YES NO venereal disease</p>
<p style="text-align: center;">MEDICATIONS:</p> <p>List medications: _____ _____ _____ Pharmacy name: _____ Phone: _____</p>		<p style="text-align: center;">ALLERGIES:</p> <p>Aspirin Sleeping pills Codeine Iodine Latex</p> <p>Local Anesthesia Penicillin Sulfa Other: _____ _____</p>	

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 ACCOUNTABILITY 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