

# WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any 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 # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Drivers License# \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex    M    F Marital Status \_\_\_\_\_  
Patient Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_  
Notify in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Primary Insurance

Person Responsible for Account \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Phone \_\_\_\_\_  
Person Responsible Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber # \_\_\_\_\_ Ins Phone Number \_\_\_\_\_  
Name of other dependents under this plan \_\_\_\_\_

## Additional Insurance

Is patient covered by additional insurance?    Yes    No  
Subscriber Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Group # \_\_\_\_\_  
Ins Phone Number \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Name of other dependents under this plan \_\_\_\_\_

## Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## MEDICAL HISTORY

Patient Name:	
Physician's Name:	
Address:	
Telephone No:	Date of last visit:
Your current physical health is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Are you currently under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what?	
Are you taking any prescription or over-the-counter drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list name and dosage:	

**Women:**

Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No
If pregnant, what week are you in? <span style="float: right;">Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</span>

**Have you ever had any of the following diseases or medical problems?**

<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters
<input type="checkbox"/> Y <input type="checkbox"/> N Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma
<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Drug/Alcohol Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes
<input type="checkbox"/> Y <input type="checkbox"/> N HIV	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatism
<input type="checkbox"/> Y <input type="checkbox"/> N Aids	<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Immune System Disorder
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone Medicine
<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver Problem	<input type="checkbox"/> Y <input type="checkbox"/> N Colitis	<input type="checkbox"/> Y <input type="checkbox"/> N Swollen Ankles
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints	<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Diet (Special/Restricted)
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Valves	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Tumors
<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous/Anxious
<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Chronic Cough
<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized any Reason	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
Do you have or have you had any disease, condition or problems not listed?		
Please list any serious medical condition(s) that you have ever had:		

**Are you ALLERGIC to any of the following drugs?**

<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline	<input type="checkbox"/> Y <input type="checkbox"/> N Latex
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics	<input type="checkbox"/> Y <input type="checkbox"/> N Sulfa
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Metals
<input type="checkbox"/> Y <input type="checkbox"/> N Acetaminophen	<input type="checkbox"/> Y <input type="checkbox"/> N Ibuprofen	<input type="checkbox"/> Y <input type="checkbox"/> N Other

Please list any other drugs that you are allergic to :

Have you ever used Phen-Fen or other appetite suppression combinations for weight loss?  Y  N

If Yes, have you had an echocardiogram?

I certify that the answers to the medical history questionnaire are accurate and correct to the best of my knowledge. Should any additional information be needed, you have my permission to contact the respective health care provider or agency, who may release such information to you. I agree to notify the dentist of any change in my medical condition or medications at any subsequent appointments.

Patient/Guardian Signature \_\_\_\_\_

Date:



## DENTAL HISTORY

Patient Name:
Address:
Telephone:

### Have you ever had:

<input type="checkbox"/> Y <input type="checkbox"/> N Have you noticed any mouth odors	<input type="checkbox"/> Y <input type="checkbox"/> N Orthodontic Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Do you get cold sores/blisters	<input type="checkbox"/> Y <input type="checkbox"/> N Oral Surgery
<input type="checkbox"/> Y <input type="checkbox"/> N Has your bite changed	<input type="checkbox"/> Y <input type="checkbox"/> N Periodontal Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Do your gums bleed or hurt	<input type="checkbox"/> Y <input type="checkbox"/> N Bite adjusted or teeth ground
<input type="checkbox"/> Y <input type="checkbox"/> N Do you have loose/missing teeth	<input type="checkbox"/> Y <input type="checkbox"/> N A bite plate or mouth guard
<input type="checkbox"/> Y <input type="checkbox"/> N Do you smoke/chew tobacco	<input type="checkbox"/> Y <input type="checkbox"/> N Popping or clicking of the jaw
<input type="checkbox"/> Y <input type="checkbox"/> N Clench/grind while asleep or awake	<input type="checkbox"/> Y <input type="checkbox"/> N Pain (side of face, ear, joint)
<input type="checkbox"/> Y <input type="checkbox"/> N Regularly bite your cheeks or lips	<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty opening or closing
<input type="checkbox"/> Y <input type="checkbox"/> N Mouth breath while awake/asleep	<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty chewing
<input type="checkbox"/> Y <input type="checkbox"/> N Have tired jaws, esp in the morning	<input type="checkbox"/> Y <input type="checkbox"/> N Head, neck or shoulder aches
<input type="checkbox"/> Y <input type="checkbox"/> N Snore or have any sleep disorder	<input type="checkbox"/> Y <input type="checkbox"/> N Sore muscles (neck/shoulder)
<input type="checkbox"/> Y <input type="checkbox"/> N Are your teeth sensitive to hot/cold	<input type="checkbox"/> Y <input type="checkbox"/> N A serious injury to mouth/head

What is the reason for your visit today?		
Date of your last: Dental visit:	Cleaning:	Full Mouth X-rays:
Name of your previous dentist:		
Are you currently experiencing any pain? If yes, explain:		
Your current dental health is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Do you believe your teeth are affecting your general health?		
Are you happy with your smile? <input type="checkbox"/> Y <input type="checkbox"/> N If no, explain:		
How often do you brush your teeth? <span style="float: right;">Floss?</span>		
Does your toothbrush have <input type="checkbox"/> Hard <input type="checkbox"/> Medium or <input checked="" type="checkbox"/> Soft bristles?		
Do you feel nervous about having dental treatment?		

I certify that the above answers are accurate and correct to the best of my knowledge.  
 I agree to notify the Dentist of any change in my medical condition or medications at any subsequent appointments.

Patient/Guardian Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_

**ADVANCED DENTAL CARE**  
Nader Zanzi D.M.D. , Raj Zanzi D.M. D  
6910 Douglas Blvd, Ste F, Granite Bay, CA 95746  
(916) 780-7676

OFFICE POLICY

FINACIAL POLICY

Estimated patient portions are due when services are rendered. We accept Cash, Check, Visa, Master Card, 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 parent or guardian accompanying the minor.

MISSED APPOINTMENTS

Be advised that the policy of this office is to charge **\$50.00** for failed or cancelled appointments unless we receive **48 hours business notice**. Our office hours are Monday 8AM-5PM, Tuesday 9AM-6PM, Friday 8AM-5PM, Saturday 8AM-2PM.

SERVICE CHARGE

All accounts past due are subject to 18% interest rate which will be applied to all accounts over 60 days. Fees incurred to collect payment will be billed to and payable by patient. There is a charge of **\$25.00** for all returned checks.

FINACIAL CONSENT

The patient / guardian agrees to be fully responsible for any fees acquired in this office.

**I Understand And Agree To This Policy And Agreement.**

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Signature of Patient/ Guardian

(Date)

## ADVANCED DENTAL CARE

Dr.Nader Zanzi DMD ,Dr. Raj Zanzi DMD

6910 Douglas Blvd. STE F Granite Bay, Ca 95746

(916) 780-7676

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

With my consent **Advanced 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 **Advanced 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. **Advanced 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, **Advanced 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, **Advanced Dental Care** may send patient statements and reminder cards to my home or any other designated location. **Advanced 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 **Advanced Dental Care** resrtict 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 request restrictions, but if it does, it is bound by that agreement.

By signing this form, Iam consenting to **Advanced 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 **Advanced Dental Care** may decline to provide dental treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Date

**DENTAL MATERIALS FACT SHEET**

**I HAVE RECEIVED A COPY OF THE DENTAL MATERIALS FACTSHEET AS  
REQUIRED BY LAW.**

**PATIENT SIGNATURE.....**

**(For minors parent or guardian)**

**DATE.....**