



Farshid Ariz, D.M.D., Inc.
Practice Limited to Periodontics

11633 San Vicente Blvd., Suite 216
Los Angeles, CA 90049

OFFICE POLICY

Dear patient this is to notify you and remind you of our policy. Please take a note of the following:

- 1) **It is very important that you follow Dr. Ariz' recommendation after completion of your procedure and they are as follows:**

Periodontal patients need to have 3 to 4 periodontal maintenance appointments per year. If a patient chooses not to follow this instruction the possibility of the same problem recurring again is HIGH.
- 2) Our office will forward a claim for dental visit/services rendered in this office on behalf of you (the patient) to the insurance carrier you have provided. This is only possible with a valid ID or Social Security number. **You (the patient) will be responsible for the co-payment and or any unpaid balance by your insurance carrier at the time of service.**
- 3) It is patients' responsibility to make sure that at the time of their visit they have an active and valid dental insurance. It is also your responsibility to make sure you are eligible for any treatments with us prior to your treatment.
- 4) **It is patient's responsibility to find out if there is any payment associated with your visit prior to your arrival.**
- 5) All patients are responsible to provide our office with any changes to their:
 - Insurance
 - Mailing address
 - Phone numbers
- 6) \$15 late fee will be added every month to any outstanding balance of **30** days from the date of the statement. Balance of **120** days and over will be reported to our collection agency. Any and all collection costs and attorney fees that may be required to collect the unpaid balance will be the patient's responsibility, unless other arrangements have been made with our office.
- 7) Returned checks and denied credit cards will be charged with additional \$30. Only cash payment will be accepted after that.

**PATIENT ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

Date: _____

Your have the right to refuse to sign this acknowledgment

INITIAL _____ I have read a copy of this office's NOTICE OF PRIVACY PRACTICE as required by federal law.

INITIAL _____ I am taking a copy of this office's NOTICE OF PRIVACY PRACTICE as required by federal law.

Patient Signature _____

FOR OFFICE USE ONLY

On the above date we made a "good faith effort" to obtain written acknowledgment of receipt of our NOTICE OF PRIVACY PRACTICES. We were unable to obtain acknowledgment for the following reason:

_____ Patient refused to sign

_____ Other _____
(Language difficulty, communication barriers, dental emergency)

SCHEDULING COMMITMENT

In order to accommodate and to meet a suitable appointment for you, we ask that you notify our office **NO LATER** than 24 hours prior to your appointment during our business hours for any type of rescheduling including cancellations

If rescheduling and/or cancellation happens more than once we ask that in order to secure your appointment; Patients with Insurance must pay their co-payment at the time of making their appointment. Patient without insurance pay half of their pre-estimated fee

Failure to notify our office during our business hours will be charged and responsible for:

\$150.00	for appointment with Dr. Ariz
\$100.00	for appointment with Hygienist

**THE ANSWERING SERVICE WILL ONLY TAKE MEDICAL
EMERGENCY PHONE CALLS.**

I have read and respect the scheduling commitment.

Signature: _____ Date: _____

Thank You

Health History

Patient's Name _____ Sex F M Birth date _____
 Physician's Name _____ Physician's Phone _____
 Physician's _____ Address _____ City _____ Zip _____

MEDICAL

- Are you in good health? Yes No
 Has there been any change in your general health within the past year? Yes No
 Date of last physical examination.
 Are you under the care of a physician? Yes No
 Have you ever had any serious illness, operation, or been hospitalized? Yes No
 Are you taking any drugs or medicine? If yes, list medication on the back. Yes No
 Have you ever tested positive for HIV? Yes No
 Are you sensitive or allergic to any drugs? Penicillin; Sulfa; other Yes No
 Codeine or other narcotic; Aspirin; Barbiturates; Iodine; other Yes No
 Have you taken any recreational drugs in the past year
 (cocaine, crack, marijuana, IV drugs)? Yes No
 Do you smoke? Yes No
 Do you drink alcohol? Yes No

Do you have now, or have you had in the past, any of the following?

- | | | |
|---|--|--|
| AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches or Migraines .. <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis __ Type <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes (cold sores) <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling of Feet or Ankles .. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, Persistent or Bloody. <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor/Growth-Head/Neck <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthetic Replacement .. <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you wear contact lenses <input type="checkbox"/> Yes <input type="checkbox"/> No | Phen Phen <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight loss (unexplained) .. <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you have any other illness not mentioned above:

Women: Are you pregnant? Yes No Due date? _____ Are you nursing? Yes No
Women: Do you use an Oral Contraceptive or other hormonal therapy? Yes No
 Do you have any disease, condition, or problem not listed above that you think we should know about? Yes No

DENTAL

- Are you happy with your smile? Yes No
Have you ever had any unfavorable reaction from a local anesthetic? Yes No
Have you had any serious trouble associated with any previous dental treatment? Yes No
How long since your last full mouth X-rays?
How long since your last dental treatment?
Do you require Antibiotics prior to dental treatment? Yes No

List of Current Medications

I understand that withholding any information about my health could result in adverse reactions during dental treatment. Therefore, I have reviewed this medical history and have carefully answered these questions to the best of my knowledge. I also understand it is my responsibility to update this office of any changes in my medical history.

Signature Date Reviewed by: _____ Date
Patient, Parent, Guardian Doctor

ANNUAL HEALTH HISTORY UPDATE

Date Health Changes and Current Medications

Patient Signature Reviewed By Dr. _____ Date

Date Health Changes and Current Medications

Patient Signature Reviewed By Dr. _____ Date

Date Health Changes and Current Medications

Patient Signature Reviewed By Dr. _____ Date

Date Health Changes and Current Medications

Patient Signature Reviewed By Dr. _____ Date

CONFIDENTIAL PATIENT INFORMATION

I. GENERAL INFORMATION

Patient's Name: _____ Male Female Birth Date: _____
(Last) (First) (Middle)

Single Married (Spouse's Name) _____ Widow Divorced Separated

Home Address: _____ City: _____ Zip: _____

Phone: () _____ Driver's License No.: _____ Social Security No.: _____

Cell: () _____ E-mail Address: _____

Employed by _____ Occupation: _____
(if self, please state business name)

Business Address: _____ City: _____ Zip: _____ Phone: () _____
(ext)

Spouse Employed by: _____ Occupation: _____

Business Address: _____ City: _____ Zip: _____ Phone: () _____
(ext)

Cell: () _____

Who Referred you to us ? _____ Phone: () _____
(We wish to thank them) (ext)

II. FINANCIAL INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ Soc. Sec. No.: _____

Home Address: _____ City: _____ Zip: _____ Phone: () _____
(ext)

IN CASE OF EMERGENCY CONTACT

Name of Nearest Relative: _____ Relationship: _____

Address: _____ City: _____ Zip: _____ Phone: () _____
(ext)

II. DENTAL INSURANCE INFORMATION

This information is necessary to make sure you receive the maximum benefits that you are entitled to. Thank you.

Employee's Name: _____ Soc. Sec. No.: _____

Employed by: _____ Birth Date: _____

Group or
Name of Insurance Co. or Union: _____ Union No.: _____

If patient is covered by more than on dental insurance, please complete the following:

Name of Spouse: _____ Social Sec. No.: _____ Relationship: _____

Employed by: _____ Birth Date: _____

Group or
Name of Insurance Co. or Union: _____ Union No.: _____

AUTHORIZATION TO PAY BENEFITS TO DENTIST

I hereby authorized payment directly to the above dentist for the surgical and/or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

Signature: _____ Date: _____

IV. GENERAL CONSENT AND FINANCIAL RESPONSIBILITY STATEMENT

(Including Terms and Conditions)

The undersigned hereby authorizes Dr. Farshid Ariz to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Ariz to make a thorough diagnosis of patient's dental needs. I also authorize Dr. Ariz to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the above named patient and further authorize and consent that Doctor choose and employ such assistance, as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. **I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.** I further understand that a \$15 late fee will be added to any balance over 30 days. In the event of default I (We) promise to pay legal interest on the interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this note.

Signature: _____ Date: _____