Raj Zanzi, DMD Insiya Zanzi, DDS

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_____________ Gender____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#__________________________ Insurance 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________________________ Insurance Phone Number_____________
Soc Sec# ________________ Group#______________ 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________________

Health History

*Patient Name:*______________________________ *Soc Sec#:*____________________

*Birth Date:*____________________

I. CIRCLE APPROPRIATE ANSWER (leave blank if you dont understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If yes, Why?______________________________
4. Yes No Are you being treated by a physician now? If yes, Why?
   Date of last Medical Exam:____________________ Date of last appointment: ____________
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?
7. Yes No Have you ever taken Phen-Phen diet pills?
8. Yes No Have you ever taken Bisphosphonate (Fosamax)?
9. Yes No Do you have a latex allergy?
10. Yes No Do you have any allergies to: drugs, food, medications? List:____________________

II. HAVE YOU EXPERIENCED:

11. Yes No Chest pain (angina)?
12. Yes No Swollen ankles?
13. Yes No Shortness of breath?
14. Yes No Recent weight loss, fever, night sweats?
15. Yes No Persistent cough?
16. Yes No Bleeding problems, bruising easily?
17. Yes No Sinus problems?
18. Yes No Difficulty swallowing?
19. Yes No Diarrhea, constipation, blood in stool?
20. Yes No Frequent vomiting, nausea?
21. Yes No Difficulty urinating?
22. Yes No Dizziness?
23. Yes No Ringing in the ears?
24. Yes No Headaches?
25. Yes No Fainting spells?
26. Yes No Blurred vision?
27. Yes No Seizures?
28. Yes No Excessive thirst?
29. Yes No Frequent urination?
30. Yes No Dry mouth?
31. Yes No Jaundice?
32. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU EVER HAD:

33. Yes No Heart disease?
34. Yes No Heart attack, heart defects?
35. Yes No Heart Murmur?
36. Yes No Rheumatic fever?
37. Yes No Stroke, hardening of arteries?
38. Yes No High blood pressure?
39. Yes No TB, emphysema, lung disease?
40. Yes No Stomach problems, ulcers?
41. Yes No Family history of diabetes, heart problem, tumors?
42. Yes No Psychiatric care?
43. Yes No Radiation treatments?
44. Yes No Chemotherapy?
45. Yes No Prosthetic heart valve?
46. Yes No Artificial joint?
47. Yes No Venereal Disease(Syphilis, etc.)
48. Yes No AIDS or ARC?
49. Yes No Tumors or cancer?
50. Yes No Arthritis, rheumatism?
51. Yes No Eye disease?
52. Yes No Skin disease?
53. Yes No Anemia?
54. Yes No Pacemaker?
55. Yes No Herpes?
56. Yes No Kidney, bladder disease?
57. Yes No Thyroid, adrenal disease?
58. Yes No Diabetes?
59. Yes No Hospitalization?
60. Yes No Blood transfusion?
61. Yes No Surgery?
62. Yes No Contact lenses?

IV. ARE YOU TAKING:

63. Yes No Recreational drugs?
64. Yes No Drugs, medicines (including over the counter)?
65. Yes No Tobacco in any form?
66. Yes No Alcohol?

If yes, Please list:______________________________

V. WOMEN ONLY:

67. Yes No Are you or could you be pregnant or nursing?
68. Yes No Birth control pills?

VI. ALL PATIENTS:

69. Yes No Do you have or have you ever had any other diseases or medical problems NOT listed on this form?
    If yes, please explain:______________________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication as soon as possible.

*Patient or Guardian Signature:*______________________________ *Date:*____________________

*Reviewed by:*______________________________ *Date:*____________________

RAJ ZANZI, DMD
INSIYA ZANZI, DDS

Twelve Bridges
DENTAL

OFFICE POLICY

FINANCIAL POLICY

Estimated patient portions are due when services are rendered. We accept cash, checks, Visa, Mastercard, Citi-Health, and Care Credit. ***(patient initial)*** ___________

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 a 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. The patient is the responsible party if dental treatment is not covered or exceeds the insurance allowance. ***(patient initial)*** ___________

MINORS

Treatment of minors can not be performed without parent or guardian accompanying the minor. ***(patient initial)*** ___________

MISSED APPOINTMENTS

Be advised that the policy of this office is to charge $50.00 for failed or canceled appointments unless we receive 48 hours business notice. Patients are requested to kindly confirm their appointments 48 hours prior to their scheduled time. Appointments can be confirmed via email/phone or text for your convenience. We reserve the right to take the patient off our schedule if we cannot confirm the appointment after repeated attempts by our staff. ***(patient initial)*** ___________

Office hours:
Monday 8AM-5PM, Tuesday 9AM-5PM, Wednesday 9AM-6PM, Thursday 9AM-5PM, Friday 8AM-5PM

SERVICE CHARGES

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 the patient. There is a charge of $25.00 for all returned checks. ***(patient initial)*** _____

FINANCIAL CONSENT

The patient (or guardian) agrees to be fully responsible for any fees acquired in this office. I understand and agree to this Office Policy and Agreement. ***(patient initial)*** _____

_______________________________________ ____________________

Signature of Patient / Responsible Party *Date*

RAJ ZANZI, DMD
INSIYA ZANZI, DDS
916.797.0825

1424 BLUE OAKS BLVD.
ROSEVILLE, CA 95747

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

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

I have the right to review the Notice of Privacy Practices prior to signing this consent. Twelve Bridges Dental Group reserves the right to revise this Notice of Privacy Practices at any time. A revised Notice of Privacy 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, Twelve Bridges Dental Group may call my home or other designated location and leave a message in voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and health care operations. I consent to the dental practice using my cell phone number to call or text regarding appointments or treatment. ***(patient initial)*** ________

I also consent to receiving email communications from the dental practice regarding treatment, insurance, my account, and special promotions. I understand that I can withdraw my consent at any time. ***(patient initial)*** ________

With my consent, Twelve Bridges Dental Group may send patient statements and reminder cards to my home or any other designated location. Twelve Bridges Dental Group may post the daily schedule, in designated areas to assist the staff in carrying out dental treatment. I have the right to request that Twelve Bridges Dental Group 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 Twelve Bridges Dental Group's 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, Twelve Bridges Dental Group may decline to provide dental treatment.

______________________________ ______________________________

Signature of Patient or Legal Guardian *Print Name of Patient or Legal Guardian*

____

Date

Raj Zanzi, DMD

Twelve Bridges
DENTAL

Insiya Zanzi, DDS

Dental Materials Fact Sheet

I have reviewed a copy of the Dental Materials Fact Sheet as required by law.

*Patient Signature*__________________________________
(or minor's parent or guardian)

*Date*______________