

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Gender: _____ Family Status: _____
 Social Security #: _____ Birth Date: _____ DL# _____
 Phone (Home): _____ (Work): _____ (Cell): _____
 Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
 Email Address: _____
 Address: _____
Street Apartment #

City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | OTHER: |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Smoke (past/present) | |

• Have you ever had any complications following dental treatment? Yes No
 If yes, please explain: _____

• In case of an emergency who should we contact? Please list there contact information.

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
 If yes, please explain: _____

• Are you now under the care of a physician? Yes No
 If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

• List any medication that you are currently taking. _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

 Signature of patient, parent or guardian Date: _____

 Signature of Dentist Date: _____

Referral Information

Name of person or office referring you to our practice: _____
 Dental Office Yellow Pages Newspaper School Work Other _____

Insured or Responsible Party Information

The following is for: the patient the patient's parent / guardian

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____ DL#: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

City

State

Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's ID #: _____ Group #: _____

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Deductibles, co-payments, and co-insurance amounts are "out of pocket" expenses and are YOUR responsibility to pay. As these amounts are subject to change without prior notification, we may not always ask you to pay the correct amount at the time of your visit. Anything we ask you to pay for at the time of service is an estimate of what you will owe. If we have asked you to pay less than the correct amount shown on the explanation of benefits we receive from your insurance company, we will bill you for the difference. Should you have any questions, please refer to your plan booklet, or you may contact your employer, insurance agent, or insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

Hamid Atabakhsh, D.D.S., P.A.
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RELEASE FOR X-RAY EXAM

Lead Lined aprons are used for **each** patient's protection. If you have any questions ask your dentist or contact your healthcare provider.

If you are pregnant or think you may be, it is important to us that all precautions are taken to minimize any exposure. X-rays will not be utilized without permission from your physician.

Patient Signature

Date