



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

III. DO YOU HAVE OR HAVE YOU EVER HAD: _____

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

IV. ARE YOU TAKING: _____

- | | |
|---|---------------------------------|
| 63. Yes No Recreational drugs? | 65. Yes No Tobacco in any form? |
| 64. Yes No Drugs, medicines (including over the counter)? | 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: _____



OFFICE POLICY

FINANCIAL POLICY

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

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.

MISSED APPOINTMENTS **(patient initial)** _____

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.

Office hours:

Monday 8AM-5PM, Tuesday 9AM-5PM, Wednesday 10AM-7PM, 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.

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.

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

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 _____