OMID FARAHMAND, D.M.D.

PATIENT INFORMATION

Patient Name:_____ Date:_____
Last First MI (Preferred Name)

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Social Security #:_____ Driver's License:_____ DOB:_____

Tel (Home):_____ (Work):_____ (Cell):_____ Email:_____

Address:_____
Street Apt # City State Zip Code

Emergency Contact: Name:_____ Tel:_____

HEALTH INFORMATION

Have you ever had any of the following? Plea Please checl yes or no to each one

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Cough, Persistent	☐	☐	Hepatitis	☐	☐	Rheumatic Fever
☐	☐	Allergies	☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Sickle Cell Anemia
☐	☐	Anemia	☐	☐	Dizziness	☐	☐	Joint Replacement	☐	☐	Sinus Problems
☐	☐	Arthritis	☐	☐	Drug Addiction	☐	☐	Kidney Disease	☐	☐	Stomach Problems
☐	☐	Artificial Heart Valves	☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐	Stroke
☐	☐	Artificial Prosthesis	☐	☐	Fainting	☐	☐	Mental Illness	☐	☐	Surgical Implant
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease
☐	☐	Back Problems	☐	☐	Growths	☐	☐	Nervous Disorders	☐	☐	Tobacco Habit
☐	☐	Blood Disease	☐	☐	Hay Fever	☐	☐	Pacemaker	☐	☐	Tonsilitis
☐	☐	Cancer	☐	☐	Head Injuries	☐	☐	Parkinson's Disease	☐	☐	Tuberculosis
☐	☐	Cerebral Palsy	☐	☐	Heart Disease	☐	☐	Psychiatric Treatment	☐	☐	Ulcers/Colitis
☐	☐	Chemotherapy	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Venereal Disease/STD
☐	☐	Circulatory Problems	☐	☐	Herpes	☐	☐	Respiratory Treatment	☐	☐	Other_____

1. Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
   If **YES**, please explain:_____
2. Are you now under the care of a physician? ☐ Yes ☐ No
   If **YES**, please explain:_____
3. Name of Physician:_____ Tel:_____
4. Do you have any health problems that need further clarification? ☐ Yes ☐No
   If **YES**, please explain:_____
5. Are taking any medications or herbal supplements? ☐ Yes ☐ No
   If **YES**, please list:_____
6. Are sensitive or allergic to any medications? ☐ Yes ☐ No
   □ Penicillin □ Tetracycline □ Sulfa Drugs □ Codeine □ Aspirin □ Other_____
7. Are you sensitive or allergic to Latex? ☐ Yes ☐ No
8. Do you take or have you ever taken **Bis-Phosphates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.)** for osteoporosis or any any other condition? ☐ Yes ☐ No
9. Have you ever taken Phen-Phen/Redux? ☐ Yes ☐ No
10. **Women:** Are you pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No Are you taking Birth Control Pills? ☐Yes ☐No
11. Date of last dental visit:_____ Reason for this visit:_____
12. Have you ever had any complications following dental treatment? ☐ Yes ☐ No
    If YES, please explain:_____
13. Do you bleed excessively when cut? ☐ Yes ☐ No
14. Have you ever been **pre-medicated** with antibiotics for your dental treatment? ☐ Yes ☐ No
15. Have you ever had a local anesthetic (Novocaine etc) ☐ Yes ☐ No
16. Have you ever had any unfavorable reaction from a local anesthetic? ☐ Yes ☐ No
17. What concerns so you have about your teeth?_____

_____ _____ _____
Signature of Patient, Parent or Guardian Date Relationship to Patient

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #:_____ Driver's License #:_____ DOB:_____

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

Address:_____

Street Apt # City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Occupation:_____

Address:_____ Tel:_____

Street City State Zip Code

Insurance Information - Primary

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No

Last First MI

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

Insured's Employer Name:_____

Address_____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No

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

Insured's Employer Name:_____

Address:_____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

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.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental servies. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by the insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will charged on all accounts exceeding 60 days, unless previously financial arrangements are satisfied.

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 Dentist, I agree to pay therefore the reasonable value of said services to said Dentist, or his assignee, at the time said services are rendered, or within five (**5**) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be 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

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