WELCOME!

So that we can provide you with the best possible care please complete these forms. all information is completely confidential.

WE LOVE TO SEE YOU SMILE

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:

LAST FIRST MIDDLE

☐MALE ☐FEMALE ☐ CHILD ☐SINGLE☐MARRIED☐DIVORCED☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

HOME:
CELL:
WORK:
OTHER:

E-Mail:

Referral? ☐Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

Patient Signature _____ Date_____

Dentist Signature _____ Date_____

LONE TREE DENTAL GROUP
MARYAM E. KHAKPOUR DDS
ARTISTRY • INTEGRITY • PASSION

WWW.LONETREEDDS.COM
Tel: 925.605.9393
5421 LONE TREE WAY #110
BRENTWOOD, CA 94513

PREVIOUS DENTIST INFORMATION

Dentist: ..... Telephone: .....

Address: .....
CITY ST ZIP CODE

What is the reason for your visit today?: .....

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: ..... Last X-rays: .....

☐Y☐N Are you currently having dental discomfort? If yes, explain: .....
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: .....
☐Y☐N Any injuries to mouth/teeth/head/neck? .....
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced? If yes, how long ago?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Do you have sensitivity to hot or cold? Or when you chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you smoke/ chew tobacco or use any other tobacco products?
☐Y☐N Have you ever been told to take a pre-medication prior to dental treatment?
☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

.....

The most important concerns regarding my dental treatment are:

.....

What factors are most important for your satisfaction with our office?

.....

What would you say has been the biggest barrier in preventing you from getting your dental treatment done?

.....

☐Y☐N Do you experience clicking or popping of the jaw?

.....

☐Y☐N Difficulty in chewing on either side? .....
☐Y☐N Have you noticed any loose teeth? .....
☐Y☐N Would you like to keep your teeth all of your life?

.....

PRIMARY PHYSICIAN

Physician/Facility: ..... Telephone: .....

Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

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MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years?
☐Y☐N Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing Bisphosphonates ?
☐Y☐N Taking medications, pills or drugs? If Yes, Type:
☐Y☐N Have you ever taken Phen-fen or Redux?
☐Y☐N Do you take St. John's Wort product?

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: .....

Are you on a special Diet ? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐AIDS/ HIV POSITIVE
☐ALZHEIMER'S DISEASE
☐ANAPHYLAXIS
☐ANEMIA
☐ANGINA
☐ARTHRITIS/ GOUT
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ASTHMA
☐BREATHING PROBLEMS
☐BLOOD DISEASE
☐BLOOD TRANSFUSION
☐BRUISE EASILY
☐CANCER/MALIGNANCY
☐CHEMOTHERAPY
☐CHEMICAL DEPENDENCY
☐CHEST PAINS
☐CONVULSIONS
☐CONGENITAL HEART DISORDER
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐EXCESSIVE BLEEDING
☐ FREQUENT COUGH/ HEADACHES
☐HAY FEVER
☐HEART ATTACK/FAILURE
☐HEART PACEMAKER
☐HEART MURMUR
☐HEPATITIS A, B, C
☐HIGH /LOW BLOOD PRESSURE
☐HEMOPHILLIA
☐KIDNEY DISEASE
☐LIVER DISEASE
☐ MITRAL VALVE PROLAPSE
☐OSTEOPEROSIS
☐OTHER – PLEASE LIST:
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RHEUMATIC/SCARLET FEVER
☐SHINGLES
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? ☐NONE

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐ACRYLIC
☐OTHER – PLEASE LIST:
☐CODEINE
☐ SULFA
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐PENICILLEN/ OTHER ANTIBIOTICS
☐TETRACYCLINE

MEDICATION INFORMATION

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

Patient Signature: _____ Date: _____ Dentist Signature: _____ Date: _____

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Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

No estimate is a guarantee of payment. Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

Minors must be accompanied by a parent or legal guardian. If the parents are separated or divorced, the person accompanying the minor will be responsible for copayment at the time of service.

Payments

Patient portion or patient co-pay is due at the time services are rendered - unless prior financial arrangements have been made.

Payment Information:

- All major credit cards are accepted (Visa, MasterCard, Discover, American Express)
- 10% Discount for our uninsured cash/check paying patients
- Various financing options with CareCredit® and CitiHealth®

Balances: We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact Paulette promptly for assistance in the management of your account.

Short Cancelled/ Missed Appointments

Please give 48 hours notice if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

Short canceled or missed appointments will be charged one dollar per minute of time allotted for your appointment.

By signing below I acknowledge I have read and understand the guidelines above.

Signature:_____ Date: _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: **Date:**

RELATIONSHIP TO PATIENT: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

☐ I give permission for the following communications to be used by Dr. Maryam E. Khakpour DDS, **(please check all that apply)**:
☐Cell phone: ☐Text Message reminders permitted
☐Home phone☐Work☐E-Mail:

☐I am granting permission for Dr. Maryam E. Khakpour DDS to disclose their identity to anyone who may answer my home, work or cell phone.

☐I am granting permission for Dr. Maryam E. Khakpour DDS to leave a message with any person who may answer my phone or on my voicemail of the following numbers**(please check all that apply)**:
☐Home Phone ☐Cell Phone ☐Work Phone☐None- please just ask for a call back
☐Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other – please list:

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PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize Doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name) _____'s dental needs. Upon such diagnosis, I authorize Doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I hereby authorize Doctor to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____