PAGE MANSOURIAN DDS INC
COSMETIC & GENERAL DENTISTRY

4015 Mission Oaks Boulevard, Suite A, Camarillo, CA 93012 • P/ (805) 987-2701 • www.smilebydrm.com

Welcome

Thank you for selecting our dental health care team!

We will strive to provide youwith the best possible dental care. To help us meet all your dental health care needs, ease fill out this form completely in ink. If you have any questions or need assistance, please ask us – *we will be happy to help you.*

Patient # _____

SS#/SIN _____

Date _____

Patient Information (Confidential)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State ____ Zip/P.C. _____

e-Mail _____ Cell Phone _____

Check Appropriate Box ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If Student, Name of School/College _____ City _____ State/Prov _____ ❑ F/T ❑ P/T

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State ____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You to Our Office? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

e-Mail _____ Cell Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ SS#/SIN _____

Is the Person Currently a Patient in our Office? ❑ Yes ❑ No

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State ____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip/P.C. _____

How Much is Your Deductioble? _____ Max Annual Benefit _____ How Much have You Used? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ Yes ❑ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State ____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State _____ Zip/P.C. _____

How Much is Your Deductible? _____ Max Annual Benefit _____ How Much have You Used? _____

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Patient Medical History

Physician _____ *Office Phone* _____ *Date of Last Exam* _____

	Yes	No
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	❑	❑
3. Are you taking any medication (s) including non- prescription medicine? If yes, what medication(s) are you taking? _____ _____ _____	❑	❑
4. Have you taken medication for osteoporosis?	❑	❑
5. Have you ever taken Fen-Phen / Redux?	❑	❑
6. Do you use tobacco?	❑	❑
7. Do you use controlled substances?	❑	❑

9. Are you allergic to or have you had any reaction to the following:

	Yes	No
- Local Anesthetics (e.g. Novacain)	❑	❑
- Penicillin or any other Antibiotics	❑	❑
- Sulfa Drugs	❑	❑
- Barbiturates	❑	❑
- Sedatives	❑	❑
- Iodine	❑	❑
- Aspirin	❑	❑
- Any Metals (e.g. nickel, mercury, etc)	❑	❑
- Latex Rubber	❑	❑
- Other (please list) _____	❑	❑

10. *Women Only*

	Yes	No
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking oral contraceptives?	❑	❑

8. Do you have or have you had any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains
❑	❑	Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded
❑	❑	Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke
❑	❑	Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever / Allergies
❑	❑	Fainting / Convulsions	❑	❑	Frequently Tired	❑	❑	Tuberculosis
❑	❑	Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy
❑	❑	Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma
❑	❑	Epilepsy / Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss
❑	❑	Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease
❑	❑	Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble
❑	❑	Kidney Diseases	❑	❑	Hepatitis / Jaundice	❑	❑	Respiratory Problems
❑	❑	AIDS or HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Mitral Valve Prolapse
❑	❑	Thyroid Problem	❑	❑	Stomach Troubles / Ulcers	❑	❑	Other _____

Patient Dental History

Previous Dentist and Location _____ *Date of Last Exam* _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you ever experienced any of the following problems in your jaw?		
- Clicking	❑	❑
- Pain (joint, ear, side of face)	❑	❑
- Difficulty in opening or closing	❑	❑
- Difficulty in chewing	❑	❑
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you ever had any prolonged bleeding following extractions?	❑	❑
13. Have you had any orthodontic treatment?	❑	❑
14. Do you wear dentures or partials?	❑	❑
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth & gums?	❑	❑
16. Do you like your smile?	❑	❑

Authorization and Release

I certified that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) _____

Doctors Comments:

Signature _____ *Date* _____

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Financial Policy/Contract

Our financial policy is based on the open and honest communication. We are very proud of our fees and our commitment to the quality of care we provide our patients. To avoid any misunderstandings, **all charges for dental services provided are the direct responsibility of the patient,** regardless of whatever dental plan you have chosen yourself. We encourage you to ask any questions that may allow us to help put your mind at ease, remove any anxieties, and make your experience as pleasurable as possible.

- Payment in full is required each time of service where charges are incurred. If you have a dental plan that we have agreed to bill for you, **your co-payment will be estimated and due at each visit.**
- Any treatment recommended by Dr. Mansourian is based upon your real healthcare needs and not what your company wishes you would do as they are not licensed healthcare providers. Rest assured that we are all patients ourselves and our own family. We feel that, professionally speaking, our patients are family too.
- As a courtesy to our patients, we offer our assistance to you in billing your plan for you based upon the accuracy of the information you provide us based upon your understanding the following: all dental plans are contracted between the insured and the plan providers; our office is a third party to any such agreement. All plans are different. There are instances where the employees whom work for the same employer have different benefit tables. You are solely responsible for keeping track of the benefit due you, how much you have used (including visits to other specialist), and your plans annual maximums. To protect your good standing and avoid finance charges and late fees, familiarize yourself with your dental plan as you are responsible for assuring that any claims be paid in a timely manner. Delayed insurance remittance will place your account in default.
- **Appointments**: we greatly respect your time and respectfully ask the same in return. Your appointment is time reserved solely for you. Schedule changes cause great disruption to the office and many others. We ask that you avoid schedule changes. In the event that it is absolutely necessary to change or cancel any time reserved for you, **48 hour notice is required** (voice mail cancellations are discouraged) **initial**_____**.** We reserve the right to charge substantially for any time that has been lost. Standard cancellation fees are equal to either $200.00 per hour or time reserved or the full procedure. Repeat offenders will be required to pay in full prior to appointing.
- FORMS OF PAYMENT ACCEPTED: Cash, Check, Visa, Master Card, American Express, Discover, Care Credit, and Chase Health Advance. ALL PATIENTS ARE REQUIRED A VALID PHOTO ID.

Signature _____ Printed Name _____

Date _____

Relationship to patient ❑ Self ❑ Parent/Guardian ❑ Other _____

Witness/Staff Official _____

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Acknowledgement of Receipt

You may refuse to sign this Acknowledgement

I,_____ have received a copy of:

❑ *Dr. Page Mansourian's Notice of Privacy Practices*

❑ *Dental Material Fact Sheet (Dated 2004)*

_____ _____

Patient's Signature *Date*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and/or Dental Materials Fact Sheet, but could not be obtained because:

❑ Individual refused to sign

❑ Communication barriers prohibited obtaining the acknowledgement

❑ An emergency situation prevented us from obtaining acknowledgement