Mardirossian Periodontics & Implant Dentistry

Welcome

1. About You

Today's Date _____ File # _____

Patient Name _____
LAST FIRST MI

What You Prefer To Be Called _____ ❑ Male ❑ Female

Birthdate _____ Age _____ SS# _____

Mailing Address _____

_____
CITY STATE ZIP

Home Phone # _____

Work Phone # _____ Ext. _____

Cell Phone # _____

E-mail Address _____

Referred By _____

Employer How Long?

Employer's Address

CITY STATE ZIP

Occupation

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name

Do you have children? ❑ Yes ❑ No How Many?

2. Insurance Info

PRIMARY DENTAL INSURANCE

Co. Name _____

Address _____

_____
CITY STATE ZIP

Phone # _____

Insured's ID# _____

Group # (Plan, Local, or Policy #) _____

Insured's Name _____

Relation _____ Date of Birth _____

Insured's Employer _____

SECONDRY DENTAL INSURANCE

Co. Name _____

Address _____

_____
CITY STATE ZIP

Phone # _____

Insured's ID# _____

Group # (Plan, Local, or Policy #) _____

Insured's Name _____

Relation _____ Date of Birth _____

Insured's Employer _____

3. Account Info

Person ultimately responsible for account

Name _____

Relation _____

Billing Address _____

_____
CITY STATE ZIP

SS # _____

Drivers License # _____

Work Phone # _____

Payment method ❑ Cash ❑ Check

_____ _____/_____

❑ Credit Card - Enter card # above (if accepted)

_____
Initials

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office)

4. In Event of Emergency

Whom should we contact? _____

Relation _____

Home Phone # _____

Work Phone # _____

Cell Phone # _____

Who is your Medical Doctor? _____

Medical Doctor's Phone # _____

Paseo Del Sol Medical Center • 13197 Central Ave., Ste. 201 • Chino, CA 91710
Tel. 909-613-1366 • Fax 909-613-1477

5. Dental Information

Reason for today's visit ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How long? _____

Please indicate ☑ any of the following problems

❑ Discomfort, clicking or popping in jaw
❑ Red, swollen or bleeding gums
❑ Sensitive tooth, teeth or gums
❑ Blisters/sores in or around the mouth
❑ Other _____
❑ Lost/Broken Fillings
❑ Teeth grinding
❑ Ringing in ears
❑ Broken/Chipped tooth
❑ Stained Teeth
❑ Locking Jaw
❑ Bad breath

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist _____
NAME PHONE

Last Dental exam ____/____/____ Last Dental X-rays ____/____/____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6. Medical History

What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ Others _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/Stroke	**Y N** Thyroid Problems	**Y N** CancerTumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/Rheumatism	**Y N** Difficulty Breathing
Y N Artifical Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had _____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Dental Anesthetics
❑ Foods _____ ❑ Others _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10 _____ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ I acknowledge that I have recieved a copy of the Summary of Privacy Notice.
Initials

Signature _____ Date ____/____/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

_____ ____/____/____
Initials Date
Comments

_____ ____/____/____
Initials Date
Comments

_____ ____/____/____
Initials Date
Comments

Mardirossian Periodontics & Implant Dentistry

Armen Mardirossian, D.D.S., M.S.
Periodontics & Dental Implants
Diplomate, American Board of Periodontology

WE'RE CONCERNED ABOUT YOU

We understand that you are unique and have unique concerns. So that we can provide you with the best possible care, please check off the statements that apply to you.

Name _____ YES NO

1.	I am nervous being in a dental chair	_____	_____
2.	I have had a bad experience in a dental chair	_____	_____
3.	I sometimes get dizzy lying back in a dental chair	_____	_____
4.	I have had difficulty with gagging or suctioning	_____	_____
5.	I would like to take breaks during long appointments	_____	_____
6.	My teeth or gums are very sensitive	_____	_____
7.	I am comfortable with dental noises (drilling or suctioning)	_____	_____
8.	I haven't been to the dentist in a long time and am afraid of what you might say about my teeth or dental hygiene	_____	_____
9.	I would like extra care to relieve pain	_____	_____
10.	I am comfortable being informed to by the doctor	_____	_____
11.	I will need to relay what you tell me to my spouse/other	_____	_____
12.	I have a fear of receiving injections	_____	_____
13.	I have concerns about the appearance of my teeth or smile	_____	_____
14.	I have concerns about eating, chewing, or bad breath	_____	_____
15.	I have concerns about insurance or finances	_____	_____
16.	I have another question or concern (please write below)	_____	_____

_____

_____

Thank you for giving us your thoughts.
Dr. Mardirossian & Staff

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Periodontal Specialist Appointments

We ask for 48 hours notice to cancel or reschedule appointments

A **$25 fee** will be charged for appointments canceled without a 2-business cay notice prior to appointment time. This includes consultation, recall/observe or re-evaluation appointments.

We kindly ask for a **deposit of $200 per hour** for surgery appointments. This deposit will be applied towards your patient portion that is due for treatment. If 2-business day notice prior to appointment time is not given to reschedule or cancel your appointment, then the deposit is forfeited and a new deposit will be needed to reschedule the appointment. If no deposit is collected then there is a **$200 per hour** broken appointment fee if the 2-business day notice is not given to the office by the patient.

I undersigned, have read, understand and agree to the above.

I prefer to pay my deposits with the following payment method:

_____ Cash _____Check _____Credit Card

_____ _____

Patient Name Date

_____

Patient Signature (or responsible party)

_____

Witness

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Patient Partnership Financial Policy

Dear Patient:

Welcome to our Practice! This is our office financial policy agreement. As a courtesy, we will bill your insurance company. After your insurance company processes the claim, if there is any remaining balance on your account, you will receive 2 statements and a courtesy call.

If the balance is not paid within 60 days of your first statement, your account will be forwarded to an outside collection agency.

I, _____ understand and agree to this Financial Policy.

_____ _____ _____

Patient Date Dentist Office Representative

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but could not be obtained because:

- ❑ **The patient refused to sign**
- ❑ **Due to an emergency situation it was not possible to obtain an acknowledgment**
- ❑ **We weren't able to communicate with the patient**
- ❑ **Other (Please provide specific details)**_____

_____

_____

_____ _____
Employee Signature *Date*

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/2003, and will remain in effect until we replace it.

We reserve the right to change out privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about your treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to obtain payment for services we provide you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connections with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluations practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS We must disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide your with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may disclose your health information when we are required to do so by law.