

Dr. Massoud Eftekhari www.VIPdentistryAZ.com

Patient Information

Name:		Preferre	d Name:	
Home Address		City:	State	Zip:
Home #:	Work	#2	Mobile #:	anning de la companya
Email:	and the second s			
Sex: M / F	Birth Date://_	SS#:		ACCOUNTS AND ADDRESS OF THE AC
Family Status (circle): Single Married	Divorced Child Spo	use's Name:	meneral in his not observed one play of the last of annual reading bloods and delicate a delicate described and
How did you fi	rst hear about our office?	(circle one):	N.	
Another Patie Facebook Sign –Drive b	Work	School		Online Search Insurance Website
Whom may we	thank for referring you t	o our practice?		
Person Re	sponsible for Ac	count		
Name of respon	nsible party:			
Relationship to	patient (Circle): Self Sp	ouse Parent Other:_	ar yana and halika kan kan kan kan kan kan kan kan kan k	
Home Address:	Vinderstanding date (MARING CONTROL CO	City;	State:	Zip:
Home #:	w	ork #:	Mobile #:	
Email:				
Birth Date:	// SS#:		and the state of t	
Contact In	<u>formation</u>			
What is the bes	t way to communicate wi	th you? Home Phone /	Mobile Phone/ Tex	t / Email
In the event of a	an emergency, whom sho	uld we contact? Name_		
Relationship	Home #:	Work #	:Mob	ile #:
Print na	ame:	Patient Signa	ture:	Date:



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Medical History

Patient Name:		aller and the property of the Parket	Date of Birth:				
1. Date of last physical exam:			Physici	an's Nam	e: ne#:		hours and providing fill initial risk page.
2. Have you eve	er been hospitaliz	ed (if yes, e			LOP.		And a second
	on under the care what for?		al doctor durin	g the pas	t two years?	es No	PROPERTY CONTRACTOR AND
4. Have you eve	er had any excessi you pregnant/tr	ve bleeding				es No es No	versitetet dan der
	-			o any of	the following (plea		
Local Anestheti	ic Penicill	lin C	odeine		Other Antibiotic:		
Latex	Acrylic	M	letals		Other:		
7. Are you takir	ng or have you eve	er taken anv	y of the followi	ing medic	cations (please circ	le if vesì:	
Fosamax	Actone		oniva	0	For how long?		
Aredia	Reclast	2	ometa		When did you sto		
8. Are you takir	ng any BLOOD TH	INNER? Ye	s No If yes p	lease list	S 	and the state of the	DESPRIMENTAL MAIN COMME
9. Please list of	her medications	you are taki	ing:				
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And the color that and the transfer and the color of the		Territoria de la compositoria della compositoria de	And the state of t			en e	SACO AND
Have you eve	r had any of th	e followin	ng?				
Chest Pains	Yes No	Shortness o		Yes No	Hives/Ski	n Rashes	Yes No
Heart Failure	Yes No	Ulcers		Yes No	Alcoholism	n .	Yes No
Heart Disease	Yes No	Mental Hea	alth Issues	Yes No	Herpes		Yes No
Heart Attack	Yes No	Emphysem	a	Yes No	Glaucoma		Yes No
Heart Problems	Yes No	Fainting/Di	izziness	Yes No	Steroid Tr	eatment	Yes No
Angina Pectoris	Yes No	Eating Diso	order	Yes No	Arthritis		Yes No
Heart Surgery	Yes No	Epilepsy/Se	eizures	Yes No	Dental Imp	olant	Yes No
Liver Disease	Yes No	Persistent (Cough	Yes No	Dentures/	Partials	Yes No
Hypertension	Yes No	Tuberculos	is	Yes No	Birth Defe	cts	Yes No
Heart Murmur	Yes No	Asthma		Yes No	HIV+, AIDS	, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A		Yes No	Hay Fever		Yes No
Psychiatric Treatment	Yes No	Hepatitis B		Yes No	Tobacco P	roducts	Yes No



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Signature: Date Doctor's Signature											
Artificial joints Yes No Night Sweats Yes No Kidney Trouble Yes No Thyroid Disease Yes No Stroke Yes No Diabetes Yes No Blood Transfusion Yes No Drug Addiction Yes No Chemotherapy Yes No Blood Transfusion Yes No Cold Sores Yes No Cancer Yes No Mitral Valve Prolapse (MVP) Yes No Radiation Therapy Yes No Transplant Yes No COPD Yes No Date of last dental x-rays: 2. Previous dentist's name / location: 3. Are you having tooth or gum pain at this time? Yes No A. Do you feel nervous about having dental treatment? Yes No No South yes No	Sickle Cell Disease Yes No	He	oatits C or D	Yes	No	Bruise	e Easily	() 	7	/es	No
Thyroid Disease Yes No Stroke Yes No Diabetes Yes No Diabetes Yes No Anemia Yes No Drug Addiction Yes No Chemotherapy Yes No Blood Transfusion Yes No Cold Sores Yes No Cancer Yes No Mitral Valve Prolapse (MVP) Yes No Radiation Therapy Yes No Transplant Yes No COPD Yes No Date of last dental x-rays: Dental History 1. Date of last dental exam: 2. Previous dentist's name / location: 3. Are you having tooth or gum pain at this time? Yes No A. Do you feel nervous about having dental treatment? Yes No No A. Do you feel nervous about having dental treatment? Yes No No A. Do you gums bleed when brushing / flossing? Yes No No No No Yes No No No No Yes No	Sinus Trouble Yes No	Pac	emaker	Yes	No	Jaund	ice		7	les	No
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Difficulty opening or closing Yes No Bad Taste Bad Breath Difficulty chewing Yes No Food Catching Tooth Pain History of trauma to jaw or face Yes No Clenching Grinding Diagnosis of TMJ/TMD Yes No Other: I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate. Signature: Date Doctor's Signature	Pain in or around your ears	Yes	No	Swel	lling		Bleedi				
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Diagnosis of TMJ/TMD Yes No Other:	History of trauma to jaw or face	Yes	No		-						1
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	Doctor's Signature							***************************************	AVORANO CUENÇO DE SERVICIO.		
	Doctor's Notes:							the second section of the second	the property of the party of th	ritarios	

Financial Guidelines

Payment for treatment is due and payable the day services are rendered. It is our goal, however, to assist all of our patients in obtaining the dental treatment they deserve. Therefore, we are pleased to offer several payment options. Our financial coordinator will answer any questions you may have, and assist you in selecting the appropriate financial plan for your needs.

If a discount is given for x-rays, the original amount must be paid in full before x-rays can be transferred.

A record transfer fee of \$25 may be applied for transfer of x-rays.

Discounts for treatments are void if the entire treatment is not completed for any reason, original fees will be applied.

Dental Insurance

We are happy to file insurance claims and assist you in obtaining the maximum benefits specified in your contract. However, please keep the following in mind:

- Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract. We will do our best to ESTIMATE your coverage, and file your insurance on your behalf. Not all dental services are necessarily covered under your dental insurance plan. It is essential that you read and understand your coverage and pay special attention to any preauthorization requirements, exclusions and waiting periods.
- Our office policy states that you are totally responsible for your bill. The ESTIMATED patient portion of the fee is due at the time of service. If a balance remains after we receive payment from your insurance carrier within 30 days we will notify you. Failure of your insurance carrier to reimburse our office within 30 days will result in our billing you directly for the remaining balance.
- We are committed to providing the highest quality of care. Our treatment recommendations
 and the dental services we provide are in the best interest of the patient's health. The
 patient is responsible for payment in full regardless of an insurance company's arbitrary
 determination of treatment necessity.

Patients initial	Date	



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Acknowledgement of Receipt of Notice of Privacy Practices

you about our privacy practices by available online. If you prefer a pap I acknowledge that a copy of this of	maintain the privacy of your health information and to inform providing you with a Notice of Privacy Practices. Our Notice is er copy, please ask a team member for a copy of our Notice. Iffice's Notice of Privacy Practices has been made available to me to ask any questions I may have regarding this Notice.	
Signature	Date	
	FOR OFFICE USE ONLY	
We attempted to obtain written ack acknowledgement could not be obt	mowledgement of receipt of our Notice of Privacy Practices, but ained because:	
\square Individual refused to sign		
☐ Communication barriers pro	phibited obtaining the acknowledgement	
☐ An emergency situation pre	vented us from obtaining the acknowledgement	
□ Other (Please Specify)		
	-	