VIP
Family & Sedation Dentistry

830 S Main Street 1-D
Cottonwood, AZ 86326
928-634-5566

Dr. Massoud Eftekhari
www.VIPdentistryAZ.com

Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: M / F Birth Date: ___ /___ /_____ SS#:_____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other:_____	

Whom may we thank for referring you to our practice?_____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State: _____Zip: _____

Home #: _____Work #: _____ Mobile #: _____

Email: _____

Birth Date: ___ /___ /_____ SS#:_____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Home #: _____ Work #: _____ Mobile #: _____

_____ _____ _____

Print name: Patient Signature: Date:

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Medical History

Patient Name: _____ **Date of Birth:** _____

1. Date of last physical exam: _____ Physician's Name: _____
   Physician's Phone#: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No

_____

3. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. **Women:** Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other: _____

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? _____
Aredia	Reclast	Zometa	When did you stop? _____

8. Are you taking any BLOOD THINNER? Yes No If yes please list: _____

9. Please list other medications you are taking:

_____

_____

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	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 Products	Yes No

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Sickle Cell Disease	Yes	No	Hepatits C or D	Yes	No	Bruise Easily	Yes	No
Sinus Trouble	Yes	No	Pacemaker	Yes	No	Jaundice	Yes	No
Artificial Joints	Yes	No	Night Sweats	Yes	No	Kidney Trouble	Yes	No
Thyroid Disease	Yes	No	Stroke	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						

Dental History

1. Date of last dental exam:_____ 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
4. Do you feel nervous about having dental treatment?	Yes	No
5. Have you ever had a bad experience in a dental office?	Yes	No
6. Do your gums bleed when brushing / flossing?	Yes	No
7. Have you ever seen a periodontist?	Yes	No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)?	Yes	No
9. Is there anything you would like to speak with the Doctor about in private?	Yes	No
10. Would you be interested in discussing ways to improve your smile?	Yes	No

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking in jaw joint	Yes	No	Sensitivity to:	Hot	Cold	Sweets	Biting
Pain in or around your ears	Yes	No	Swelling		Bleeding Gums		
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_____

Doctor's Notes:

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

Patient Name: _____

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a Notice of Privacy Practices. Our Notice is available online. If you prefer a paper copy, please ask a team member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____

Signature **Date**

----------FOR OFFICE USE ONLY----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify)