

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out the following forms as completely as you can. If you have any questions we will be glad to assist you. We look forward to working with you in maintaining your oral health.

Patient Information

Date _____

Name: Last _____ First _____

ID/SS# _____ / _____ / _____ Driver's License _____ Sex: M ___ F ___ Age _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Home Telephone (_____) _____ Work Telephone (_____) _____ Cellular Number (_____) _____

Employer _____ Occupation _____

IN CASE OF EMERGENCY, CONTACT: Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Whom may we thank for referring you? _____

Dental Insurance

Subscriber's Name _____ ID/SS# _____ Birth Date _____

Address (if different from patient's) _____

Subscriber's Employer _____ Occupation _____

Insurance Co _____ Group # _____

Relationship to Patient _____ Is patient covered by additional insurance? Yes ___ No ___

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with above named insurance company and assign directly to Dr. Ghotanian all insurance benefits. I understand that I am financially responsible for all charges whether or not covered by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also understand that all payments of services rendered are due upon commencement.

Responsible Party Signature

Relationship

Date

Office Policy

If unable to keep any appointments kindly give 24hr notice otherwise we reserve the right to charge \$50 per half hour for time appointed.

Responsible Party Signature _____

Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-rays _____

Check if you have had any of the following:

Bad Breath Yes ___ No ___

Bleeding Gums Yes ___ No ___

Cigarette, pipe or cigar smoking Yes ___ No ___

Loose teeth or broken filling Yes ___ No ___

Periodontal treatment Yes ___ No ___

Sensitive to cold, heat or sweets Yes ___ No ___

Sores or growth in mouth Yes ___ No ___

How often do you floss/brush? _____

Patient Acknowledgment of receipt of Dental Materials Fact Sheet

I, _____, acknowledge that I have received from _____
patient name dentist or dental office name
a copy of the Dental Materials Fact Sheet

Patient Signature Date

The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet; and its linkage to the DCA web site does not constitute an endorsement of the content of this document.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, have received a copy of Dr. Ghotanian's office's Notice of Privacy Practices.

{Please Print Name}

{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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

