

MEDICAL HEALTH HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physician's name: _____
		Physician's phone: _____
Are you wheel chair dependent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Are there any disabilities (physical or mental) that the office should be aware of?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Are you on a special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Do you use controlled substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____
Do you use a C-Pap machine for Sleep Apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: _____

Women: Are you _____

Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Trying to get pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	---	--

Are you allergic to any of the following? _____

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic	<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Local Anesthetics	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Other If yes, please explain: _____							

Do you have, or have you had, any of the following? _____

<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Shingles
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Angina	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach/Intestinal Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Heart Pace Maker	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Asthma	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Autism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Herpes	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

As a courtesy to our patients, if you are 10 minutes late for your appointment we may have to reschedule, but we will try our best to accommodate you.

A 48 hr. notice is required; otherwise there is a missed appointment fee of \$25.00 - \$100.00 charged to your account.

PATIENT DENTAL HISTORY

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/food? | <input type="checkbox"/> | <input type="checkbox"/> | a) Clicking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/food? | <input type="checkbox"/> | <input type="checkbox"/> | b) Pain (joint, ear, side of face)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have pain in any of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> | c) Difficulty in opening or closing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | d) Difficulty in chewing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any orthodontic work? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you clench or grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 9. Do you bite your lips or cheeks frequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 10. Have you ever had any difficult extractions in the past? | <input type="checkbox"/> | <input type="checkbox"/> |

What is the reason for your visit today? _____

Date of last dental visit: _____

What was done at your last dental visit? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

Welcome to all new and established patients. We wish to thank you for choosing us as your dental care provider. Our objective is to provide you with the highest quality dental care in the most cost-effective manner. However, the ability to achieve this objective depends greatly on your understanding of our financial policy. If you have dental insurance we will file insurance claim forms on your behalf. **We do this as a courtesy to our patients.** Even though we will file insurance claims for you, we need your active participation in the insurance claims process.

COMMERCIAL INSURANCE PATIENTS:

Insurance coverage is not a guarantee of payment. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Insurance companies frequently set fees below our customary charges. You are still obligated to pay the full amount (meaning that you are responsible for paying the amount that your insurance may say is "above their customary fees) unless we have negotiated a discounted fee schedule with that particular insurance company.

PPO PLAN: If we are participating providers in you PPO, we will submit a claim for you. **If you have not met your deductible or have a co-pay, this is due at the time of service.** You are required to pay your co-payment at each office visit.

PATIENTS WITH NO INSURANCE:

Please understand that you are responsible for the balance due on your account as a result of any and all professional services rendered by this office, regardless of your insurance status. Payments may be made to this office with cash or personal checks.

- **A \$25.00 fee will be assessed on all returned checks.**
- **A \$25.00 fee will be assessed for any bills sent to your home 30 days past due.**

(continued on back)

As a courtesy to our patients, if you are 10 minutes late for your appointment we may have to reschedule, but we will try our best to accommodate you.

A 48 hr. notice is required; otherwise there is a missed appointment fee of \$25.00 - \$100.00 charged to your account.

FINANCES

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. If you have any questions concerning financial arrangement it will be our pleasure to assist you. We do accept Cash, Checks, Major Credit Cards, Debit Cards, and Care Credit.

In the case of children of divorced parents, the custodial parent will be financially responsible for providing this office with repayment, regardless of divorce settlement.

X

Signature of patient or parent if minor

date

Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist 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 on behalf of my dependents.

X

Signature of patient or parent if minor

date

HIPAA

I have read and understand the HIPAA information posted on the wall in the waiting room of Dr. Raffi Leblebajian.

X

Signature of patient or parent if minor

date

As a courtesy to our patients, if you are 10 minutes late for your appointment we may have to reschedule, but we will try our best to accommodate you.

A 48 hr. notice is required; otherwise there is a missed appointment fee of \$25.00 - \$100.00 charged to your account.