Westlands Parks Advanced Dentistry

Patient Information

Patient Registration

Patient Name: _____
Preferred Name: _____
Guardian Name (Under 18) : _____
Relations to the Patient _____
Date of Birth: _____ Age: _____
Gender: ☐ Male ☐ Female ☐ Prefer not to disclose
Marital Status:
☐ Married ☐ Widowed ☐ Single ☐ Divorced
Home Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____
Cell Phone: _____
Home Phone: _____
Work Phone: _____
Employer: _____
Social Security Number: _____
Emergency Contact Name: _____
Emergency Contact Phone: _____
Referred By: _____

Insurance Information

Primary Insurance: _____
Phone #: _____
Insurance Address: _____
City: _____ State: _____ Zip: _____
Plan #_____ Group # _____
Policy # _____
Policy Owner Name: _____
Relationship To Patient: _____
Policy Owner Date of Birth: _____
Policy Owner Social Security #: _____
Policy Owner Employer: _____
Address: _____

Secondary Insurance: _____
Phone #: _____
Insurance Address: _____
City: _____ State: _____ Zip: _____
Plan #_____ Group # _____
Policy # _____
Policy Owner Name: _____
Relationship To Patient: _____
Policy Owner Date of Birth: _____
Policy Owner Social Security #: _____
Policy Owner Employer: _____
Address: _____

Dental History

Purpose of Today Visit: _____
Previous Dentist: _____
Previous Dentist Phone: _____
Date of Last Cleaning: _____
How often do you brush? _____
How often do you floss? _____
Have you had any head and neck trauma?_____
Have you had any Gum Surgery?_____
_____
Have you had any of the following?
☐ Orthodontics ☐ Implants ☐ Root Canals
☐ Crowns ☐ Veneers ☐ Gum Disease
_____
Are you please with appearance of you smile?
☐ Yes ☐ No

Additional Questions and Comments:
_____
_____
_____
_____
_____

Signature On File

Dr. Mani Farzim *is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.*

I hereby authorize payment directly to **Mani Farzim DDS** *of the dental benefits otherwise payable to me.*

_____
Patient signature

_____
Date

Receipt of Privacy Practices Notice

I, _____ Acknowledge that I have received a ***Notice of Privacy Practices*** *from Westlands Park Advanced Dentistry.*

_____ _____

Signature *Date*

_____ _____

Legal Representative *Relationship to patient*

Please list any other parties who are actively involved in your health care and who can have access to your health information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact form this office to confirm my appointment, treatment and billing information via:

☐ *Cell phone* ☐ *Text message* ☐ *Home phone* ☐ *Email* ☐ *Work phone* ☐ ***Any of the above***

Financial Policy

If we accept your insurance plan we are happy to bill for your office visit; However, if you do not have insurance, payments for services due at the time services are rendered. We accept cash, checks, American Express, Discover, Mastercard and Visa. Returned check and letter to you requiring certified mail will be subjected to $25.00 service charge added to your account. Charges may also be made for copy of medical reports and medical records.

Please be advised that if for whatever reason your insurance company deny your claim, you are responsible for all charges from the date services are rendered.
If you have any questions regarding your account or your insurance, please contact our billing office at 303-771-7907

Acknowledgment of Financial/Record Responsibility

The information provided by me to **Mani Farzim DDS** *is true to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney fees and cost of collection in the event of default. I also hereby authorize* **Mani Farzim DDS** *to furnish to obtain any/all information to/from insurance plans, social security administration, the referring doctor(s) or PCP. Physicians, Other agencies to who we ever, or designated next of kin or caregiver concerning treatment. I authorize insurance company to send payment directed to* **Mani Farzim DDS.**

_____ _____

Signature *Date*

General Consent

I consent to diagnosis and preventive procedures and treatments provided tome by **Mani Farzim DDS***, including but not limited to, diagnostic tests, cleaning, X-Rays, exams, and any other procedures that is deemed necessary.*

_____ _____

Signature *Date*

_____ _____

Legal Representative *Relationship to patient*

Medical History

Patient Name: _____ Date of Birth : _____
Guardian Name under 18: _____ Relationship to the Patient : _____
Name of Primary Care Doctor: _____
Primary Care Phone: _____
Primary Care Address: _____
Are you currently under a physician care? ☐ Yes ☐ No
When was your last complete physical exam? _____
Have there been recent changes in your health? _____
Current prescription medications? _____
_____
Over the counter medications? _____
Are you allergic to any medications or substances? _____
Have you been hospitalized or seriously ill within the past five years? _____
Have you been treated with bisphosphonates for osteoporosis? _____
Are using recreational drugs? _____
Do you smoke? How many Pack a day? _____
Do you drink alcohol? How may drinks a week? _____

Women only

Are you pregnant or suspect you may be? How many months? _____
Do you take birth control medications? _____

Circle if you have ever had:

Heart Disease _____	Y	N	Liver Problems _____	Y	N
High/Low Blood Pressure _____	Y	N	Thyroid Problems _____	Y	N
Artificial Heart Valve _____	Y	N	Kidney Problems _____	Y	N
Angina _____	Y	N	Organ Transplant _____	Y	N
Pace Maker _____	Y	N	Joint Surgery _____	Y	N
Hear Murmur _____	Y	N	Artificial Joint Knee/Hip/Shoulder _____	Y	N
Prolonged Bleeding _____	Y	N	Arthritis _____	Y	N
Blood Disorders: Anemia, Leukoplakia ____	Y	N	TMJ Problems _____	Y	N
Head Injury _____	Y	N	Rheumatic Fever _____	Y	N
Stroke _____	Y	N	Hepatitis B/C _____	Y	N
Bell's Palsy/Trigeminal Neuralgia _____	Y	N	Recurrent Infections _____	Y	N
Epilepsy/Seizures _____	Y	N	Mouth Ulcers _____	Y	N
Migraines _____	Y	N	Tuberculosis _____	Y	N
Dizziness _____	Y	N	Treated for AIDS/HIV _____	Y	N
Frequent Headaches _____	Y	N	Hey Fever _____	Y	N
Asthma / COPD _____	Y	N	Unexplained Weight Loss _____	Y	N
Sinus Problem _____	Y	N	Cancer/ Chemotherapy _____	Y	N
Ulcer/Colities _____	Y	N	Radiation Therapy _____	Y	N
Stomach Problems _____	Y	N	Glaucoma _____	Y	N
Chronic Diarrhea _____	Y	N	Psychiatric/Emotional issues _____	Y	N
Acid Reflux _____	Y	N	Others _____	Y	N
Diabetes _____	Y	N			

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____
Signature *Date*

_____ _____
Legal Representative / Guardian *Relationship to patient*