Dr Marjaneh Azin

WELCOME

Date:_____

Patient Information (Confidential)

Cell phone number: _____

Child's name:_____ **Birth date:**_____ **Home Phone:**_____

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

Father's Name:_____ **Employer:**_____ Work #:_____

Business Address:_____ City:_____ State:_____ Zip:_____

Mother's Name:_____ **Employer:**_____ Work #:_____

Business Address:_____ City:_____ State:_____ Zip:_____

Whom may we thank for referring you?
☐Yellow Pages ☐ Doctor_____ ☐ Patient_____ ☐ Other_____

Person to Contact in Case of Emergency?_____

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name:_____ **Relation to Patient:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

SS NO:_____-_____-_____ **Employer:**_____

DOB:_____/_____/_____ **Address:**_____

Insurance Company:_____ **Group No:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name:_____ **Relation to Patient:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

SS NO:_____-_____-_____ **Employer:**_____

DOB:_____/_____/_____ **Address:**_____

Insurance Company:_____ **Group No:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

RESPONSIBLE PARTY

Name:_____

Signature:_____

Dr Marjaneh Axin

HEALTH HISTORY

Child's Name:_____
Chief Oral Compliant:_____
Date of Last Exam:_____
Any Previous Unfavorable Dental Experience: ___Yes ___No
Explain:_____

Does your child have or use any of the following; indicate with a ✓

___Traumatic injury to mouth or teeth
___Teeth sensitive to cold, heat, sweets or pressure
___Bleeding Gums How long_____
___Food Impaction
___Clenching or grinding teeth
___Swelling or lumps in mouth
___Frequent blisters on lips or mouth
___Pain around ear

___Bad Breath
___Complications from extractions
___Topical Fluoride Treatment
___Orthodontic Treatment
___Mouth breathing
___Oral Habits: thumsucking, cheek biting fingernail biting etc.

_____Texture of Toothbrush
_____Frequency of Brushing
_____Dental Floss
_____Disclosing tablets/solution
_____Fluoride supplements
_____Between meal snacks
_____Well balanced diet

MEDICAL HISTORY

Physician's Name_____ Date of Last Physical_____Child's Age___

Does your child have or use any of the following; indicate with a ✓

___Allergy to Penicillin
___Allergies to other drugs
___Allergies to anesthetics
___Any heart problems
___Radiation treatments
___Excessive bleeding form cut or extraction
___Anemia or blood problems
___Asthma
___Other

___Hay Fever of allergies in general
___Diabetes
___Kidney problems
___Liver problems or hepatitis
___Malignancies or Leukemia
___Psychiatric care/emotional problems
___Rheumatic Fever
___Immune System Disorder (AIDS, HIV, ARC)

___Sinus Problems
___Physical or mental handicap
___Thyroid disorder
___Eye disorder
___Tonsillitis
___Ulcer of colitis
___Extreme nervousness or apprehension

Describe any or current medical treatment including drugs taken, even though not listed above_____

_____

SIGNATURE:_____ DATE:_____
Parent or Guardian

Dr. Marjaneh Azin

_____
[Insert Name of Practice]

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Form No. T303HA

Dr. Marjaneh Azin

Responsibility and Consent

Date_____

I hereby authorize and request the performance of dental services for my child:

_____Age_____

_____Age_____

_____Age_____

I also give my consent for any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment.

A minimum charge will be made for failed or cancelled appointments prior to notification of **48 hours**. Once an appointment is made please remember this time has been reserved for the patient.

I understand and acknowledge that I am financially responsible for services provided for the above named, regardless of insurance coverage. In addition I will also be responsible for any collection fees.

_____

(Signature of responsible party)

_____

(Relationship)