Patient Information

Patient Name:_____ Date:_____
Last, First MI (Preferred Name)

Birth Date: _____ Gender: ___ Family Status: ___Email Address: _____

Work: _____ Employer : _____Cell: _____Phone:(Home):_____

Address:_____Drivers License #:_____
Street Apartment #

_____
City State Zip Code

IN CASE OF EMERGENCY, PLEASE CONTACT:
NAME: _____ RELATIONSHIP: _____ PHONE: _____
WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? _____
Date of Last Dental Visit: _____ Reason for this visit: _____

Please mark (X) ALL your responses to indicate if you have or have not had any of the following diseases or problems:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Growths	☐	☐	Pacemaker			
☐	☐	Anemia	☐	☐	Hay Fever	☐	☐	Current Pregnancy Due date:_____	☐	☐	Venereal Disease
☐	☐	Arthritis	☐	☐	Head Injuries				☐	☐	Codeine Allergy
☐	☐	Artificial Joints	☐	☐	Heart Disease	☐	☐	Radiation Treatment	☐	☐	Penicillin Allergy
☐	☐	Asthma	☐	☐	Heart Murmur	☐	☐	Respiratory Problems	☐	☐	Jaw Pain
☐	☐	Blood Disease	☐	☐	Hepatitis	☐	☐	Rheumatic Fever	☐	☐	Snoring Problems
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐	Sleep Apnea
☐	☐	Diabetes	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐	Other:
☐	☐	Dizziness	☐	☐	Kidney Disease	☐	☐	Stomach Problems			
☐	☐	Epilepsy	☐	☐	Liver Disease	☐	☐	Stroke			
☐	☐	Excessive Bleeding	☐	☐	Mental Disorders	☐	☐	Tuberculosis			
☐	☐	Fainting	☐	☐	Nervous Disorders	☐	☐	Tumors			
☐	☐	Glaucoma	☐	☐	Osteoporosis	☐	☐	Ulcers			

Are you allergic to any of the following: ☐ None ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Sulfa ☐ Dental Anesthetics ☐ Codeine ☐ Foods:_____ ☐ Others:_____

Current Medications:_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever taken: Bisphosphonates (ex. Aredia, Fosamax, Actonel, Boniva, Zometa) ? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a Specialty Physician? ☐ Yes ☐ No Reason: _____
- Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I grant permission to Ardalan Keshtkar, DDS and staff to take necessary x-rays, administer local anesthetic, medication and any appropriate procedures as necessary or advisable for examination, diagnosis and treatment.

_____
Signature of patient, parent or guardian Date

MEDICAL HISTORY REVIEWED AND VERIFIED BY DR. ARDALAN KESHTKAR, DDS W/PATIENT/PARENT/GUARDIAN

_____
Signature of Doctor Date

DOCTOR'S REMARKS (DATE, CLINICIAN, PATIENT SIGNATURE)

COMMENTS:_____

UPDATE:_____

UPDATE:_____

UPDATE:_____

UPDATE:_____

UPDATE:_____

UPDATE:_____

Responsible Party Information

The following is: ☐ Patient ☐ Parent of Minor/Legal Guardian

Name:_____ Birth Date: _____Social Security #: _____

Phone (Home): _____ (Work): _____ Cell: _____

Address: _____Drivers License #:_____
Street Apartment #

_____
City State Zip Code

☐ CASH ☐ Insurance ☐ In House Discount Program

Dental Insurance Plan Information

Primary Subscriber: _____ Employer Name: _____
Primary Subscriber Ins. ID# or SS #:_____Birthday: _____Grp# :_____
Primary Dental Insurance: _____ **Phone:** _____

Secondary Subscriber: _____ Employer Name: _____
Secondary Subscriber Ins. ID# or SS #:_____Birthday: _____Grp# :_____
Secondary Dental Insurance: _____ **Phone:** _____

INSURANCE ASSIGNMENT AND RELEASE OF PAYMENT

I, the undersigned certify that I (or my dependant) have insurance coverage and agree to assign all dental benefits directly to Ardalan Keshtkar, DDS. I hereby authorize Ardalan Keshtkar, DDS to release all information necessary to secure the payment of benefits and authorize this signature on all insurance related submissions.

_____

***Insured Signature** **Date**

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be estimated before treatment.

A service charge of 1 ½% per month (18% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand that the fee estimate listed for any dental care can only be extended for a period of six months from the date of the patient examination.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

I grant permission for the office of Ardalan Keshtkar, D.D.S. to telephone me at home or at my work to discuss any matters related to my (or my dependants) dental account.

You may discuss my account, or matters regarding my dental treatment with the following person(s):

_____ _____ _____

Dental Material Fact Sheet

I acknowledge that I have received the Dental Material Fact Sheet dated June 2004.

_____ Date: _____
Signature of patient, parent or guardian

DENTAL HEALTH QUESTIONNAIRE

Patient Name _____

PRESENT DENTAL CONDITION (Please circle one answer for each category)

Are you having any discomfort at this time? ***None Some A lot***
I think the present state of my teeth is: ***Very Healthy Some disease/decay In poor shape***
I feel the appearance of my smile is: ***Excellent Satisfactory Unsatisfactory***
If any, what would you like to change about your smile? ***Whiter Straighter or Other (please explain)*** _____

Improving the health of my mouth is: ***High priority Medium Low***
Improving the appearance of my smile is: ***High priority Medium Low***

PAST DENTAL CARE

*Name of previous dentist*_____*Address*_____*Phone*_____
*Date of last visit*_____ *Date of last x-rays*_____

In the past, I have gone to the dentist: ***Regularly Occasionally Emergencies***
The last dental treatment I received was for: ***Exam/Cleaning***
Filling/other restoration
Emergency care
I have had problems or pain with past dentistry: ***No Yes/Moderate Yes/Serious***
Dentistry for me and my family is: ***High priority Moderate Low***

Do you have or have you ever had any of the following:

MOUTH:

Bleeding, sore gums Y___ N___
Unpleasant taste, bad breath Y___ N___
Burning tongue or lips Y___N___
Frequent blisters, mouth or lip Y___N___
Swelling or lumps in mouth Y___N___
Orthodontic treatment (braces) Y___N___
Biting cheeks or lips Y___N___
Clicking or popping jaw Y___N___
Difficulty opening or closing jaw Y___N___
Periodontal (gum) disease Y___N___

TEETH:

Loose teeth Y___N___
Sensitive to hot Y___N___
Sensitive to cold Y___N___
Sensitive to sweets Y___N___
Sensitive to biting Y___N___
Food impaction Y___N___
Clenching/grinding Y___N___
If so, when _____
Shifting or change in bite Y___N___
Teeth Whitening Y___N___
*If so, when*_____

HOME CARE

Do you use the following?

Brush Y___ N___ ***Dental Floss*** Y___ N___
Fluoride rinse Y___ N___ ***Other*** _____ Y___ N___

How often do you brush? _____ *Brush is:* ___ ***soft*** ___ ***medium*** ___***hard***

FEELINGS ABOUT DENTAL CARE

The thought of dental care makes me: ***Not nervous Somewhat nervous Very nervous***
My greatest fear about dental care is? ***Discomfort/Pain Cost Time it takes***
What things did you enjoy about your past dental office? _____
What did you dislike about your past dental care/dental office? _____
These are the things that are most important to me about my dental health/dental care:

_____
_____
_____

Dentist Keshtkar Date

Take a few moments to tell us about your smile.	Yes	No
Have you thought about improving the appearance of your smile?		
Would you like to straighten your teeth?		
Do you have spaces that you don't like?		
Would you like to change the color of your teeth?		
Are your teeth chipped?		
Are your teeth wearing on the biting surfaces?		
What would you change about your teeth? (circle all that apply) **Color Shape Size Straighten Other:**		
Have you had orthodontic work in the past?		
Are you aware that most dental insurance plans cover orthodontic treatments which include clear aligners?		
Have you confirmed your dental insurance coverage for orthodontic treatment, including clear aligners?		

SIERRA GATE FAMILY DENTAL
OFFICE POLICY

FINANCIAL POLICY

Estimated patient portions are due when services are rendered. We accept cash, checks, Visa, Mastercard, Discover and we offer Care Credit interest free payment plan option.

INSURANCE

We will bill your insurance as a courtesy to you and it is important for you to provide us with current information. Your policy is a contract between you and your insurance company; we are not party to that agreement. Insurance policies vary, and **it is the patient's responsibility to know and understand their dental benefits**, their yearly maximum and what is left for the contractual year. Some services provided may not be a covered benefit, therefore w**e cannot be held financially responsible if dental treatment is not covered or exceeds the insurance allowance.**

MINORS

Treatment of minors can be performed without parent accompanying minor, as long as we are provided with written consent and the estimated patient portion is paid at the time of service.

MISSED APPOINTMENTS

Be advised that the policy of this office will charge **$75.00** for ***each*** failed or canceled appointments unless we receive at least a ***48 business hours notice***. We reserve the right to dismiss a patient for excessive failed or cancelled appointments. Our office hours are Monday & Wednesday 8:00 AM - 4:45 PM, Tuesday & Thursday 7:00 AM - 3:45 PM.

SERVICE CHARGES

Past due accounts are subject to 18% interest rate, which will be applied to balances that are over 60 days outstanding. Fees incurred to collect payment will be billed as well and are payable by the patient. A charge of $25.00 will be assessed for the first returned check and $30 for each additional returned check.

FINANCIAL CONSENT

The patient (guardian) agrees to be fully responsible for any fees acquired in this office.

I understand and agree to this Office Policy and Agreement.

_____ _____

Signature of patient/responsible party Date

SIERRA GATE FAMILY DENTAL
Dr. Ardalan Keshtkar D.D.S.
10 Sierra Gate Plaza, Suite #130
Roseville, CA 95678
(916) 784-0900

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED PERSONAL HEALTH INFORMATION AS IN ACCORDANCE WITH THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABLITY ACT (HIPPA), EFFECTIVE APRIL 14, 2003

With my consent, Sierra Gate Family Dental, may use disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). Please refer to Sierra Gate Family Dentalôs Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Sierra Gate Family Dental reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by calling the office at the phone number listed above. A copy will be sent to you in a reasonable amount of time.

With my consent, Sierra Gate Family Dental may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying treatment, payment and health care operations.

With my consent, Sierra Gate Family Dental may send patient statements and reminder cards to my home or any other designated location. Sierra Gate Family Dental may post the daily schedule is designated areas to assist the staff in carrying out dental treatment. I have the right to request that Sierra Gate Family Dental restrict how it uses or discloses my PHI to carry out health care and business operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by that agreement.

By signing this form, I am consenting to Sierra Gate Family Dental use and disclosure of my PHI and treatment, payment and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent Sierra Gate Family Dental may decline to provide dental treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Patientôs Name (If Different Than Above) Date