

ACCOUNT BILLING INFORMATION

Name of party to bill _____

Address if different than yours _____

City _____ State _____ Zip _____

Your Social Security # _____ Driver's License # _____

Your Employer _____

Employer Address _____

If you have dental insurance we will need the following information:

Name of insurance company _____ Ins ID # _____

Name of group/union _____ Group # _____

Mailing Address _____

City _____ State _____ Zip _____

If your spouse or another individual is providing your dental insurance or if that individual is providing secondary insurance coverage (dual coverage) for you:

We will need the following information:

Individual's Name _____

Individual's Employer _____

Individual's Social Security # _____ Birthdate _____

Name of Insurance company _____ Ins ID # _____

Name of group/union _____ Group # _____

Mailing Address _____

City _____ State _____ Zip _____

The above information will allow us to help you to obtain dental insurance benefits. PLEASE UNDERSTAND THAT INSURANCE COMPANIES PAY AT LEVELS THAT CORRESPOND STRICTLY TO THE CONTRACTED AGREEMENT MADE BETWEEN YOUR EMPLOYER AND INSURANCE CARRIER. ALLOWANCES ARE BASED ON THESE CONTRACTS, WITHOUT ANY CONSIDERATION OF YOUR BEST INTERESTS NOR ANY EXAMINATION OF YOUR INDIVIDUAL ORAL CONDITIONS.

Before any treatment is begun, we will be pleased to provide you with a detailed explanation of proposed treatments and an estimate of costs. We submit dental insurance forms as a courtesy to our patients; however, YOU are the person directly responsible for the payment of charges incurred in this office should your dental insurance company pay less than you expected. It is our policy that fees are due and payable at the time treatment is provided unless previous arrangements have been made, and that finance charges at prevailing major credit card rates may be added on balances over 30 days old, as well as any attorney or collection costs involved in closing delinquent accounts.

CONSENT TO TREATMENT

I, the undersigned, authorize doctor George S. Matosian, or his licensed staff under his direction, to examine and treat me. I have read and understand the financial and insurance information above, and have completed this health questionnaire accurately.

Signature of Patient or Guardian _____

Date _____

PATIENT QUESTIONNAIRE

Today's date _____

Patient's Name Mr. Mrs. Ms. Dr. PhD. _____ Birthdate _____

Parent's name if Patient is a minor _____

How would you prefer that we address you? _____

Residence address _____

City _____ State _____ Zip _____

Home phone _____ Cell Phone _____ Work Phone _____

Your spouse's name if applicable _____

Your profession _____

Person to contact in case of emergency _____ Phone _____

Whom may we thank for referring you to our office? _____

DENTAL HISTORY

Reason for this visit _____

Are you in pain? _____ Where? _____

Are there any particular dental problems that your previous dentist advised you that you might have?

How do you feel about coming to the dentist?

Relaxed ____ Somewhat Nervous ____ Very Nervous ____ or _____

Have you ever had an unpleasant experience in a dental setting or had a reaction to a dental anesthetic?

No ____ if Yes ____ please describe: _____

How long has it been since your last dental check up? _____

When was your last complete x-ray series taken? _____

Please go on to next page

DENTAL HISTORY (CONT'D)

Please check where appropriate:	<u>YES</u>	<u>NO</u>
Are you having any gum tissue problems?	_____	_____
Are your gums swollen?	_____	_____
Have you had gum surgery in the past?	_____	_____
Do your gums bleed easily?	_____	_____
Do you have any unhealed sore spots in your mouth?	_____	_____
Has a dental professional explained the origins of oral disease to you in the past?	_____	_____
Your comments: _____		
Do you have any soreness in your jaws?	_____	_____
Has your jaw ever locked open or closed?	_____	_____
Can you eat hard foods without pain?	_____	_____
Do you clench or grind your teeth?	_____	_____
Have you ever worn a bite protection appliance?	_____	_____
Do you commonly have headaches?	_____	_____
Have you ever broken any of the bones of your face or had a traumatic injury to your jaw, face or neck?	_____	_____
Your comments: _____		
Did you wear braces? At what age? _____ For how long? _____	_____	_____
Have you ever had your bite adjusted?	_____	_____
Are you pleased with the alignment, appearance, and/or color of your teeth?	_____	_____
Is there anything you would like to do to improve the appearance of your smile?	_____	_____
Your comments: _____		
Are there any other questions or concerns that you have about your teeth or gums? _____		

MEDICAL HISTORY

The status of your overall health is very important to our diagnosis, please complete these questions accurately.

Name of your physician _____

Address _____ Phone number _____

	<u>YES</u>	<u>NO</u>
Have you had any recent health problems?	_____	_____
If yes, please explain _____		
Are you allergic to any medications? (e.g, penicillin, novocaine, others)	_____	_____
If yes, please explain _____		
Do you have mitral valve prolapse?	_____	_____

MEDICAL HISTORY (CONT'D)

	<u>YES</u>	<u>NO</u>
Do you have an artificial or replacement heart valve?	_____	_____
Do you have any artificial joints or "Bone screws"?	_____	_____
Placement date? _____ (m/yr)		
Are you taking any medicines now?	_____	_____
If yes, please list them _____		
Are you under treatment for a personal problem?	_____	_____
If yes, for what reason? _____		
Are you pregnant or breast feeding?	_____	_____
Do you eat a specialized diet? _____	_____	_____

Please check if you are taking medicines for any of these conditions, or if you have any of these conditions:

Medicines for:

<input type="checkbox"/> Blood thinning	<input type="checkbox"/> Nervous problems (depression, anxiety)	<input type="checkbox"/> Dieting Drugs (e.g, Phen - Fen, Redux)
<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Hormone replacement therapy	<input type="checkbox"/> Osteoporosis (e.g, Fosamax, Boniva)
<input type="checkbox"/> A heart condition	<input type="checkbox"/> Allergies or asthma control	

Illnesses:

<input type="checkbox"/> Hepatitis or Jaundice	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> STD, Sexually Transmitted Disease	<input type="checkbox"/> Swollen ankles or feet
<input type="checkbox"/> AIDS or AIDS Related Complex	<input type="checkbox"/> Heart bypass surgery
<input type="checkbox"/> Organ transplants	<input type="checkbox"/> Heart attack (date _____)
<input type="checkbox"/> Lung disease (e.g. TB)	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Bleeding disorders/Transfusions	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Leukemia or other blood disease	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Tumors or cancer	<input type="checkbox"/> Asthma attacks
<input type="checkbox"/> Radiation or chemotherapy	<input type="checkbox"/> Heart Murmurs
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Drug dependency	<input type="checkbox"/> Fainting or convulsions
<input type="checkbox"/> Liver disease, Cirrhosis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Whiplash injury	<input type="checkbox"/> Stroke
<input type="checkbox"/> Thrush	<input type="checkbox"/> Arthritis or joint pain

Do you have any other medical condition that we should know of? _____