ABOUT YOU

Today's Date: ______/______/______ File #: __________

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ______________ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ______ SS#: ______________

Mailing Address: ____

____
CITY STATE ZIP

Home Phone #: (______) ______________________________

Work Phone #: (______) ______________________ Ext: ________

Cell Phone #: (______) ______________________________

E-mail Address: ______________________________________

Referred By: ______________________________________

Employer: __________________________ How Long? ________

Employer's Address: ______________________________________

____
CITY STATE ZIP

Occupation: ______________________________________

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ______________________________________

Do you have children? ❑ Yes ❑ No How many? __________

Primary Dental Insurance

Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: (______) ______________________________

Insured's ID#: ______________________________

Group # (Plan, Local, or Policy #): ______________________________

Insured's Name: ______________________________

Relation: ______________ Date of Birth: ____/____/____

Insured's Employer: ______________________________

Secondary Dental Insurance

Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: (______) ______________________________

Insured's ID#: ______________________________

Group # (Plan, Local, or Policy #): ______________________________

Insured's Name: ______________________________

Relation: ______________ Date of Birth: ____/____/____

Insured's Employer: ______________________________

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____________________________________

____
CITY STATE ZIP

SS #: ____

Drivers License #: ___________________________________

Work Phone #: (______)______________________________

Payment method: ❑ Cash ❑ Check

____ ___/___

❑ Credit Card - Enter card # above (if accepted)

________ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

EMERGENCY CONTACT

Whom should we contact?____

Relation: ____

Home Phone #: (______) ________________________________

Work Phone #: (______)________________________________

Cell Phone #: (______)________________________________

Who is your Medical Doctor?________________________________

Medical Doctor's Phone #: (______)________________________

5 DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation   Are you in pain? ❑ No ❑ Yes   How Long?______

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw ❑ Lost/Broken Filling(s) ❑ Stained teeth ❑ Broken/Chipped tooth
❑ Blisters/Sores in or around the mouth ❑ Teeth grinding ❑ Locking Jaw ❑ Sensitive tooth, teeth or gums
❑ Red, swollen or bleeding gums ❑ Ringing in Ears ❑ Bad breath ❑ Active Decay/Cavity(ies)
❑ Other: ____________________

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know   Have you ever been treated for Gum Disease? ❑ Y ❑ N

Previous Dentist: ____________ (Name) ____________ (Address) (____) ________ (Phone#)

Last Dental exam:____/____/____ Last Dental X-rays:____/____/____ Last Dental Cleaning:____/____/____

Have you had problems with previous dental treatment? If so, explain:____________________

Times a day you brush?____ Times a week you floss?____ Type of tooth brush bristles? ❑ Soft ❑ Medium ❑ Hard

Rate your Smile from 1-10 (EXCELLENT=10):______ Would you like whiter teeth? ❑Y ❑N Have you had orthodontic treatment? ❑Y ❑N

Things you would change about your smile?____________________

6 MEDICAL HISTORY & INFORMATION

What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ **Vitamins/Supplements** ____________
❑ Other(s), please list: ____________________

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No   Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Heart Attack/Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Disease/Angina	**Y N** Shingles
Y N Lung Disease	**Y N** Thyroid Problems	**Y N** Congenital Heart Defect	**Y N** Cancer/Tumor(s)/Growth(s)	**Y N** Hepatitis
Y N Liver Problems	**Y N** Seizures/Epilepsy	**Y N** Artificial Heart Valves	**Y N** Chemotherapy/Radiation	**Y N** Glaucoma
Y N Blood Disease	**Y N** Venereal Disease	**Y N** Mitral Valve Prolapse	**Y N** X-ray or Cobalt Treatment	**Y N** Arthritis/Gout
Y N Kidney Problems	**Y N** Cosmetic Surgery	**Y N** G.I. Problems/Ulcers	**Y N** Frequent Thirst/Urination	**Y N** Leukemia
Y N Scarlet Fever	**Y N** Dizziness/Fainting	**Y N** Emphysema/Asthma	**Y N** Bleeding Problems/Anemia	**Y N** Chest Pains
Y N Tuberculosis TB	**Y N** Cold/Fever Blisters	**Y N** Diabetes/Hypoglycemia	**Y N** High/Low Blood Pressure	**Y N** Bruise Easily
Y N HIV+/AIDS/ARC	**Y N** Blood Transfusion	**Y N** Psychiatric Problems	**Y N** Artificial Bones/Joints/Implants	**Y N** Allergies
Y N Rheumatic Fever	**Y N** Alcohol/Drug Abuse	**Y N** Back/Neck Problems	**Y N** Severe/Frequent Headaches	**Y N** Nervousness
Y N Sinus Problems	**Y N** Eating Disorder	**Y N** Respiratory Problems	**Y N** Jaw Problems TMJ/TMD	**Y N** Sleep Apnea

Please list any other surgeries or medical conditions you have or ever had:____________________

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Codeine
❑ Dental Anesthetics ❑ Foods: ____________ ❑ Others: ____________

Do you use tobacco? ❑ No ❑ Yes/How used?____________ How much?________ How long?______

Please rate your general health from 1-10: ____________ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No   Are you taking hormonal replacement? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long?________ Are you nursing? ❑ Y ❑ N   How many children have you had?________

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

________ (Initials) **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Signature ____________________ Date____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials	Date
	/ /
Comments	
	/ /
Comments	
	/ /
Comments	

Armen Karimyan, D. D.S.
78138 Calle Tampico, Ste. 100
La Quinta, CA. 92253

Financial Agreement and Office Policy

Please review the following carefully, then sign and date the bottom of this Agreement once you have reviewed it and understand it fully.

PAYMENT IS DUE AT THE TIME DENTAL TREATMENT IS PERFORMED.

- We accept Visa, MasterCard, and CareCredit.
- If you have dental insurance, as a courtesy to you, we will submit your insurance claim for processing. We will estimate your insurance carriers' portion and the guarantors portion due by you at the time of service. Should your insurance carrier pay less than the estimated amount you will be billed for that balance and it will be payable upon receipt.
- Financing options are available through CareCredit financing and must be secured in advance of treatment. Brochures and applications are available at the front desk. You can also apply for CareCredit online at carecredit.com Please don't hesitate to ask if you have questions or would like an application.

Appointment scheduling is a critical part of our day with that in mind, we require at least 24 hours notice to cancel or move a scheduled appointment. We make every effort to provide appointment cards and reminder phone calls for our patients so that they are informed of the next appointment they have scheduled. Cancellations or missed appointments without the **24 hour notice will be charged a $25.00** fee.

INITAL_______

By signing this agreement you understand and agree to the policies of this office. Furthermore, you understand that we do our best to estimate treatment and its cost and that final treatment is determined upon the completion of dental work.

Insurance benefits can only be ESTIMATED. A written pre-estimate/authorization of dental benefits from your insurance carrier is not a guarantee of payment. Please refer to your carrier handbook for specifics on benefit coverage for your plan. Costs not covered by your insurance carrier become the immediate responsibility of the guarantor.

Our office is not responsible for the collection of dental insurance benefits but that claims will be sent as a courtesy for the patient. We make every attempt to ensure the accuracy of your dental claim based on the information provided by each patient. It is the patients' responsibility to update the carrier information, as changes become necessary. You understand that all costs not paid by your insurance carrier are the responsibility of the guarantor and are due within 30 days. A finance charge of 1.5% per month or 13% per year will be added to all accounts over 60 days regardless of insurance coverage. I agree to pay that finance charge. INITIAL_________

In the event that legal or collection action becomes necessary, I further agree to pay ALL legal, collection and/or court costs involved.

Date:__________________ Signature:______________________________

Date:____________________ Agent for La Quinta Center for Cosmetic Dentistry:____________________

COVID-19

RISK ASSESSMENT

Dear Patient, please respond to the following questions.

	(Please circle)	
1. Do you currently have or have you had fever (100.0 F. or higher) In the past 2 weeks?	YES	NO
2. Do you currently have, or have you had a cough in the past 2 weeks?	YES	NO
3. Do you currently have or have you had shortness of breath or difficulty breathing in the past 2 weeks?	YES	NO
4. Do any of the people you have close contact with have similar symptoms?	YES	NO
5. Have you travelled outside the U.S. in the past 2 weeks?	YES	NO
6. Are you a healthcare worker who has had a recent exposure to an individual presenting symptom of respiratory illness?	YES	NO

If your answer is "YES" to any of them, we apologize and cannot see you, we recommend visiting one of the local hospitals or designated locations providing medical service to people presenting COVID-19 related symptoms.

Patient Name:____________________________________ Date:_______________

Patient Signature: ____