



All Smiles Dentistry
Shabnam Nejati, D.D.S., Inc.
 26700 Towne Centre Drive, Suite 160
 Foothill Ranch, CA 92610
 (949) 581-1500

Patient Information

Patient Name: _____ Date: _____
 Last First MI
 Male Female Married Single Child Other _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
 (Cell): _____ E-mail: _____ Driver's Lic.#: _____
 Address: _____
 Street Apartment #
 City State Zip Code

Medical Information

Have you ever had any of the following? Please circle those that apply:

- | | | | |
|------------------------|--------------------------|--------------------------|----------------------------------------------|
| Y N AIDS/HIV | Y N Dizziness/Fainting | Y N Liver Disease | Y N Thyroid Problems |
| Y N Allergies | Y N Epilepsy/Seizures | Y N Mental Disorders | Y N Tuberculosis |
| Y N Latex Allergy | Y N Glaucoma | Y N Nervous Disorders | Y N Tumors |
| Y N Penicillin Allergy | Y N Growths | Y N Pacemaker | Y N Ulcers |
| Y N Codeine Allergy | Y N Hay Fever | Y N Pregnancy-Current | Y N Venereal Disease |
| Y N Anemia | Y N Head Injuries | Due date: _____ | (HPV, Herpes) |
| Y N Arthritis | Y N Heart Attack/Disease | Y N Radiation Treatment | <input type="checkbox"/> OTHER Condition not |
| Y N Artificial Joints | Y N Heart Murmur | Y N Respiratory Problems | listed: _____ |
| Y N Asthma | Y N Hepatitis A,B, C | Y N Rheumatic Fever | _____ |
| Y N Blood Disease | Y N High Blood Pressure | Y N Sinus Problems | _____ |
| Y N Cancer | Y N Jaundice | Y N Stomach Problems | |
| Y N Diabetes | Y N Kidney Disease | Y N Stroke | |

- Are you currently taking any medication(s)? Yes No
If yes, please list: _____
- Are you or have you ever taken Phen-Fen or similar diet drugs? Yes No
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
Physician's Name: _____ Phone Number: _____
- Do you have any health problems that need further clarification? Yes No
If yeas, please explain: _____

Dental Information

- Have you ever had any complication following dental treatment? Yes _____ No _____ Please explain: _____
- Do you have a metal allergy (jewelry, etc.) ? Yes _____ No _____
- Do you have a latex allergy? Yes _____ No _____
- Are you allergic to any medications or anesthetics? Yes _____ No _____ Please explain: _____
- Do your gums bleed when you brush or floss? Yes _____ No _____
- Have you ever been advised by a physician to pre-medicate before any dental treatment? Yes _____ No _____
- Date of Last Dental Visit _____ What was done during that visit? _____

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.

Signature of patient, parent or guardian _____ Date: _____

Office Use

Reviewed by Dr. _____ Signature _____ Date: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Co

Insurance Information

PRIMARY INSURED

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

SECONDARY INSURED

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____
Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient Insurance MoneyMailer
 Valpak Coupon Yellow Pages Online Website Other _____

Name of person or office referring you to our practice: _____

Consent for Care & Treatment and Financial Policy

Consent for Care and Treatment: I the undersigned do hereby agree and give my consent for All Smiles Dentistry associates, doctors, and staff to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize All Smiles Dentistry to perform all recommended treatment mutually agreed upon by me.

Financial Policy: All payments are due at the time services are performed. If you have dental insurance coverage, we bill your personal insurance carrier solely as a courtesy to you. The estimated portion not covered by insurance must be paid at the time of service. Our office accepts cash, check, credit cards and offers convenient financing through CareCredit, Citibank, and Capital One.

If there is still a balance after you insurance company pays, that balance will be due and payable within 30 days. A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previous financial arrangements have been made in advance.

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

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

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____