ALEXANDER VASSERMAN D.D.S.

PLEASE COMPLETE THE FOLOWING INFORMANTION

1 ABOUT YOU

Today's Date:____/____/_____ Account #_____

Patient's Name:_____
LAST FIRST MI

What You Prefer To Be Called:_____ Male Female

Birthdate:____/____/_____ Age:____ SS#:_____

Mailing Address:_____

_____
CITY/REGION STATE/PROVINCE ZIP/CODE

_____ If not in the U.S.A.
COUNTRY

Home Phone #: (____)_____

Work Phone #: (____)_____ EXT:_____

Cell Phone #: (____)_____

E-mail Address: _____

Who can we thank for your Referral?_____

Employer:_____How Long?_____

Employer's Address:_____

_____
CITY/REGION STATE/PROVINCE ZIP/CODE

_____ If not in the U.S.A.
COUNTRY

Occupation:_____

Status: Minor Single Maried Divorced Separated Widowed

Spouse/Partner's Name:_____

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

2 INSURANCE INFO

Primary Dental Insurance

Co. Name:_____

Address:_____

_____

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:_____

_____

Phone #: (____)_____

Insured's ID#:_____

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

Insured's Name: _____

Relation: _____ Date of Birth:____/____/_____

Insured's Employer: _____

3 ACCOUNT INFO

Person ultimately responsible for your account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY/REGION STATE/PROVINCE ZIP/CODE

_____ If not in the U.S.A.
COUNTRY

Driver's Licence #: _____

SS #: _____

Home Phone #: (____)_____EXT:_____

Work Phone #: (____)_____ EXT:_____

Cell Phone #: (____)_____ EXT:_____

PAYMENT METHOD: ❑ CASH ❑ CHECK (U.S. ONLY)

❑ CREDIT CARD - Enter card # below (if accepted)

_____ ___/___ CVV2_____

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

RESPONSIBLE PARTY'S SIGNATURE_____ DATE_____

4 HEALTH HISTORY QUESTIONARE

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

(CARDIOVASCULAR DISORDERS)

- ❑ High blood pressure
- ❑ Congenital heart disease
- ❑ Rheumatic fever
- ❑ Heart murmur
- ❑ Mitral valve prolapse
- ❑ Heart pacemaker
- ❑ Vascular graft
- ❑ Heart or bypass surgery
- ❑ Artificial heart valve
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ Awaken with breathing difficulty
- ❑ Angina pectoris / chest pain
- ❑ Swollen ankles
- ❑ Irregular or rapid heart beats
- ❑ Stroke
- ❑ Taken Fen/Phen?

(RESPITORY DISORDERS)

- ❑ Emphysema or asthma
- ❑ Hay fever
- ❑ Chronic cough or bronchitis
- ❑ Tuberculosis (TB)
- ❑ Chronic sinusitis
- ❑ Breathing problems

(MUSCULO-SKELETAL/CNS/DEVELOPMENTAL DISORDERS)

- ❑ Frequent headaches
- ❑ Fainting spells or loss of consciousness
- ❑ Seizures or epilepsy
- ❑ Visual impairment
- ❑ Hearing impairment
- ❑ Artificial joint
- ❑ Arthritis or bone disease
- ❑ Muscle disease
- ❑ Spinal cord injury or paralysis
- ❑ Cerebral palsy
- ❑ Mental retardation / autism
- ❑ Alzheimer's disease or other dementia

(GASTROINTESTINAL/GENITOURINARY DISORDERS)

- ❑ Colitis or ulcers
- ❑ Hepatitis or other liver disease
- ❑ Jaundice
- ❑ Renal dialysis/transplant
- ❑ Kidney disease
- ❑ Syphilis/Gonorrhoea/Other sexually transmitted disease
- ❑ Genital herpes
- ❑ Frequent canker sores
- ❑ Frequent cold sores
- ❑ Chronic diarrhoea
- ❑ Frequent vomiting

(HEMATOLOGIC/ENDOCRINE/IMMUNE DISORDERS)

- ❑ Blood transfusion
- ❑ Denied permission to give blood
- ❑ Anemia/leukemia/lymphoma
- ❑ Hemophilia
- ❑ Sickle cell disease
- ❑ Blood clots or thrombosis
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Adrenal gland disease
- ❑ AIDS
- ❑ HIV infection
- ❑ Bleeding or bruising tendency
- ❑ Sudden weight loss or gain
- ❑ Frequent thirst
- ❑ Frequent hunger
- ❑ Frequent urination
- ❑ Cancer/radiotherapy/chemotherapy
- ❑ Systemic lupus

(PSYCHIATRIC DISORDERS)

- ❑ Nervousness
- ❑ Depression
- ❑ Anxiety
- ❑ Past/present psychiatric treatment

(FAMILY HISTORY)
Grandparents, Parents,Siblings, Children*

- ❑ Diabetes
- ❑ Heart diseases
- ❑ Bleeding disorders

(ALLERGIES)

- ❑ Penicillin
- ❑ Sulpha drugs
- ❑ Novocain/Xylocaine/dental anesthetics
- ❑ Aspirin
- ❑ Codeine
- ❑ Latex products
- ❑ Hay fever/pollen
- ❑ Other

(**FEMALES ONLY**)

- ❑ Are you pregnant now?
- ❑ If yes, are you in 1st or 3rd trimester?
- ❑ Are you practicing birth control?
- ❑ Do you anticipate becoming pregnant?
- ❑ Are you breast-feeding?

(DENTAL HISTORY)

- ❑ Are you having dental pain or discomfort?
- ❑ Do you feel nervous about dental treatment?

(SOCIAL HISTORY)

- ❑ Do you use tobacco?
- ❑ Alcohol addiction?
- ❑ Past or current history of drug addiction?

PLEASE LIST ANY OTHER MEDICAL CONDITION NOT MENTIONED ABOVE?

_____

HAVE YOU EVER BEEN HOSPITALIZED? ❑ Y ❑ N IF YES , WHEN _____ WHY? _____

_____

PLEASE LIST YOUR CURRENT MEDICATIONS/DRUGS/SUPPLIMENTS/VITAMINS

_____

_____

Physician's Name _____ Physician's Phone _____

In Event of Emergency Whom should we contact?_____
Relation:_____

Home Phone #: (____)_____

Work Phone #: (____)_____ EXT:_____

Cell Phone #: (____)_____

I hereby certify to my best knowledge that all of the above information is accurate and complete. Should there be a change in my medical condition I understand that in the interest of my safety I must notify Alexander Vasserman DDS and or Staff of the change.

Patient or Guardian Signature_____ DATE _____

Doctor Signature_____ Witness Signature_____

CONSENT FOR TREATMENT

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 your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for all legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. In the event payments are not recieved by agreed upon dates, a 1.5% late charge (18% APR) may be added to your account.

As you may be aware, most people do not enjoy going to the dentist and it becomes very difficult to fill in time slots for missed appointments even with a 24 HOUR NOTICE. We understand that last minute emergency events occur in our lives and out of courtesy we ask that you give us at the very least 24 HOUR NOTICE should you need to cancel your appointment. In order to discourage last minute cancellations it is our policy to charge a missed appointment administrative fee.

I hereby authorize the doctor or staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis and to document treatment. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I hereby agree to be responsible for payment of all services rendered on my behalf or my dependents.

I agree to the use of anesthetics, nitrous oxide sedation, oral sedatives and other medications as necessary. I fully understand that using these anesthetic agents and medications embodies certain risks including anaphalactic shock and extremely rare instances death. I understand that I can ask for a complete recital of any possible complications.

I authorize the provider to release any information required to process insurance or third party claim forms.

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.

This is an acknowledgement that I, _____have read and understood the Dental Materials Fact Sheet provided by the Dental Board of California.

Patient or
Guardian Signature_____ Date_____

Photographic Release

Your initials below indicate your consent for Alexander Vasserman, DDS to use, reproduce, and publish photographic or computer illustrations of your teeth/mouth/face for educational or marketing purposes, and you waive claim against any party based on the usage of the images, or make any claim that the use of the images defames you or constitutes an infringement of your rights to privacy, or any other right you may enjoy. It is not mandatory that you initial this paragraph, and you agree that if you choose to initial this paragraph, it is done so freely and voluntarily.

Client Initial_____

This form is required by the new patient privacy regulations recently issued by the United States Department of Health and Human Services pursuant to the 1996 Health Insurance Portability and Accountability Act (“HIPAA”). Prior to commencing your treatment, you must review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, photographs, x-rays, and demographic data) may be used in
connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office’s privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

_____
Patient’s Signature

_____
Print Name

_____
Date