



1122 N Brand Blvd Suite202  
Glenadale, Ca 91202  
(818) 244- 7215

# Patient Registration

Anna Acopian DMD  
Rodrick Ghadimi DMD

Sex: M \_\_\_\_\_ F \_\_\_\_\_

Patient's Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Birth-date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell Phone \_\_\_\_\_ SS # \_\_\_\_\_

Employer: \_\_\_\_\_ Who may we thank for referring you here: \_\_\_\_\_

ResponsibleParty:Last \_\_\_\_\_ First \_\_\_\_\_ MaritalStatus \_\_\_\_\_ Birthday \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Driver's license: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Phone # \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### Dental Insurance Information (Primary Carrier)

Insured's Name: \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Phone No. \_\_\_\_\_ Group # - \_\_\_\_\_

Employer \_\_\_\_\_ ID# \_\_\_\_\_

S.S. # \_\_\_\_\_ DOB: \_\_\_\_\_

### Secondary Insurance Carrier

Insured's Name: \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Phone No. \_\_\_\_\_ Group # - \_\_\_\_\_

Employer \_\_\_\_\_ ID# \_\_\_\_\_

S.S. # \_\_\_\_\_ DOB: \_\_\_\_\_

### Emergency Information: Relative not living with you.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, and therapy that maybe indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between the insurance carrier and me and not between the insurance carrier and the Doctor and I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the doctor from my insurance coverage will be credited to my account or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance.

Patient/Resp. Party: Signature \_\_\_\_\_ Date \_\_\_\_\_

**First and Last name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Dental and Medical History**

**PLEASE RATE YOUR SMILE:** 0 1 2 3 4 5 6 7 8 9 10

**Do you have any of the following? Please circle**

Bad breath   Bleeding Gums   Grinding Teeth   Sensitivity to sweets  
Sores or growths in your mouth   Food Collection between teeth   Sensitivity to hot/cold

**When was your last dental exam?** \_\_\_\_\_

**Name and location of previous dentist:** \_\_\_\_\_

	NO/YES
1. Are you currently being treated by your medical Dr. for a specific condition? .....	<input type="checkbox"/>
2. Have you ever been told that you need antibiotics prior to dental treatment? .....	<input type="checkbox"/>
3. Have you ever had a bad reaction to a dental anesthetic? .....	<input type="checkbox"/>
4. Have you had a bad experience at a dental office in the past? .....	<input type="checkbox"/>
5. Do you have pain in your chest, shortness of breath, or tiredness? .....	<input type="checkbox"/>
6. Do you ever wake up from sleep short of breath? .....	<input type="checkbox"/>
7. Do you snore at night? .....	<input type="checkbox"/>
8. WOMEN: is there a possibility that you might be pregnant? .....	<input type="checkbox"/>
9. WOMEN: are taking any oral contraceptives? .....	<input type="checkbox"/>
10. Do you ever have any clicking, popping or discomfort? In jaw joint? .....	<input type="checkbox"/>
11. Do you smoke or chew tobacco? If so which: .....	<input type="checkbox"/>

**Do you have or have you had any of the following conditions?**

	YES	NO		YES	NO		YES	NO
AIDS /HIV	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorders	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Fen-Phen/Redux/ phospho	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	ArtificialHeartvalve	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>
<b>Congestive heart disease</b>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Cong.Heart Defects	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Pace maker	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Coughs	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Phsych.Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>

**Is there any other condition that you have/had and is not listed above? Yes/No?** \_\_\_\_\_

**List medications**  
**Taken:** \_\_\_\_\_

**Are you allergic to any of the following?**

Latex products/Gloves Y/N   Seasonal allergies Y/N   Medications Y/N \_\_\_\_\_   Non-Gold Jewelry Y/N

To the best of my knowledge, all of the above preceding answers are correct, if any changes in my health occur or if my medicines change, I shall inform the Dentist and staff at the next appointment.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_

**X** \_\_\_\_\_ **Date** \_\_\_\_\_

## FINANCIAL AGREEMENT & POLICIES

**This is to inform you of our financial policy. We are committed to providing you with the finest quality care using on the best material and technology available in the market today. All charges you incur are your responsibility regardless of your insurance coverage.**

Insurance coverage is a valuable asset in restoring and maintaining good oral health. By providing us with accurate insurance information, you enable us to process your claims in a timely manner. We may also be able to determine benefits prior to treatment, which provides you with important deductible and co-payment information. Our relationship is with you as our patient, not the insurance company. Our office is not a party to that contract and final responsibility of payment is yours. As a courtesy to you, we will help you process your insurance claims. If there is no payment from the insurance company within (60) days, you will be expected to pay the balance in full.

**I am aware that unless other specific arrangements are made beforehand, payment is due at the time of treatment. We accept cash, Checks, Visa, Master Card, Amex, Discover and Care Credit(Third party financing). There is a \$25 charge for returned checks.**

**All missed appointments (those without 48 hours notice) will be assessed a charge of \$50.00**

I hereby acknowledge that I have read, understand and agree to abide by the terms set forth in this document, regardless of any insurance coverage I may have, I am responsible for payment of my account.

Patient/Responsible party: \_\_\_\_\_ Date: \_\_\_\_\_