620 E. Glenoaks Blvd.
Suite B
Glendale, CA 91207
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_____ **S S #**_____

Employer: _____. Who may we thank for referring you here: _____

ResponsibleParty:Last_____First_____MaritalStatus_____Birthday_____

Mailing Adress:_____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?	
2. Have you ever been told that you need antibiotics prior to dental treatment?	
3. Have you ever had a bad reaction to a dental anesthetic?	
4. Have you had a bad experience at a dental office in the past?	
5. Do you have pain in your chest, shortness of breath, or tiredness?	
6. Do you ever wake up from sleep short of breath?	
7. Do you snore at night?	
8. WOMEN: is there a possibility that you might be pregnant?	
9. WOMEN: are taking any oral contraceptives?	
10. Do you ever have any clicking, popping or discomfort? In jaw joint?	
11. Do you smoke or chew tobacco? If so which:	

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

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

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: _____