Sharon Ben-Roohi, D.D.S, Inc.

Family & Cosmetic Dentistry

Thank you for choosing our practice for your oral health care. Our team will strive to provide you with the best service possible. To help us get acquainted, please fill out these forms completely. Thank you and we welcome you to our practice.

PATIENT INFORMATION

Date: _____

Patient Name: _____

Date of Birth: _____/_____/_____ Age: _____

S.S # _____-_____-_____

I wish to be called _____

Address _____

(Street Address) (Apt #)

_____

(City) (State) (Zip Code)

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Email Address: _____@_____

I wish to be contacted by, **(please circle all that apply),**

CELL HOME WORK EMAIL

Occupation: _____

If full time student, School Name:_____

Employer Name: _____

Phone Number: _____

Martial Status **(please circle all that apply)**

SINGLE MARRIED DIVORCED PARTNERED

SPOUSE'S /PARTNER'S INFO

Name: _____

Phone Number ( ) _____

Date of Birth _____/_____/_____

SS # _____-_____-_____

Spouse's Employer Name: _____

Phone Number ( ) _____

Address _____

(Street Address) (Apt #)

_____

(City) (State) (Zip Code)

DENTAL INSURANCE

Subscriber: _____

Relationship to patient: _____

Insurance Company: _____

Subscriber ID Number: _____

Covered by additional insurance? Yes No

Subscriber's name: _____

Date of Birth _____/_____/_____

S.S # _____-_____-_____

Relationship to patient _____

Insurance Company _____

ASSIGNEMENT AND RELEASE:

I certify that I, and /or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Sharon Ben-Roohi all insurance benefits, if any, Name of Insurance Company (ies) rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize the use of my signature on all insurance submissions.

EMERGENCY CONTACT:

Emergency Contact _____

Relation to patient _____

Date of Birth _____/_____/_____

Phone ( ) _____

Work ( ) _____ Ext _____

Cell ( ) _____

Address _____

(Street address) (Apt #)

_____

(City) (State) (Zip Code)

Continue on next page….

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Reason for this visit, please describe: _____

_____

Our office appreciates all referrals; who may we thank for recommending us? _____

DENTAL HISTORY:

Date of last dental visit: _____ last set of X-rays:_____

Previous Dentist: _____ Phone: _____

Location: _____

How do you respond to dental treatment? (Very nervous) 5 4 3 2 1 (not a problem)

Have you ever had or currently have **(please check all that apply) :**

☐ Yes	☐ No	Orthodontic Treatment (Braces)	☐ Yes	☐ No	Oral Surgery	☐ Yes	☐ No	Your bite adjusted
☐ Yes	☐ No	Periodontal Treatment (gums)	☐ Yes	☐ No	Loose Permanent Teeth	☐ Yes	☐ No	Gum Bleeding
☐ Yes	☐ No	Hot/ Cold Tooth Sensitivity	☐ Yes	☐ No	Pain when Biting	☐ Yes	☐ No	Sores in mouth
☐ Yes	☐ No	Pain in Jaw Joint/ Ear	☐ Yes	☐ No	Difficulty Opening or Closing	☐ Yes	☐ No	Difficulty Chewing
☐ Yes	☐ No	Jaw Joint Noises or Discomfort	☐ Yes	☐ No	Bad Breath			
☐ Yes	☐ No	Packing Food between Teeth						

Do you **(check all that apply):**

☐ Yes	☐ No	Clench or Grind your teeth while asleep or awake?	☐ Yes	☐ No	Bite your lips, cheeks or nails regularly?
☐ Yes	☐ No	Mouth Breathe while awake or asleep?	☐ Yes	☐ No	Do you get food caught between your teeth?

What **do** you like about your teeth or smile?

_____

What **don't** you like about your teeth or smile? _____

How often do you floss? _____

How often do you brush? _____

Type of brush you use? _____

Have you ever whitened your teeth? If so, how was that experience? _____

_____ _____

Continued on next page….

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MEDICAL HISTORY:

Please list all medications you are currently taking and have taken within the past two months:

_____

Are you allergic to any of the following?

☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Nitrous Oxide	☐ Yes	☐ No	Local Anesthetic	☐ Yes	☐ No	Iodine
☐ Yes	☐ No	Codeine	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No	Latex

Please list all other allergies:_____

Check any of the following you have had or have now:

☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	HIV/AIDS
☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Ulcer	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Cancer
☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Glaucoma
☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No	Drug/Alcohol Dependency
☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Tobacco Habit	☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Blood Transfusion
☐ Yes	☐ No	Artificial Heart Valves	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Rheumatism
☐ Yes	☐ No	Epilepsy\Seizures	☐ Yes	☐ No	Hemophilia			
☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Herpes	☐ Other _____		

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

_____

List any other information we should know about your health _____

_____

AUTHORIZATION

I hereby authorize Dr. Sharon Ben-Roohi and the Dental Office to administer such medication and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct, to the best of my knowledge. I grant Dr. Sharon Ben-Roohi and her staff to release my dental/medical histories and related information about my dental treatment to third party payers and/or other healthcare professionals.

I authorize release of all information, photos, x rays and records to dental publications, insurance companies, dental committees and associations as deemed necessary by Dr. Sharon Ben-Roohi _____(initial)

_____ _____ _____

Signature Print Name date

Sharon Ben-Roohi, D.D.S, Inc.

Family & Cosmetic Dentistry

APPOINTMENT SCHEDULING AND CANCELLATIONS

When we make your appointment, we are reserving a block of time in our schedule specifically for you. All of us in the office prepare and look forward to your visit. We meet as a team and discuss the specifics of your treatment. We make calls to your insurance company on your behalf as your records are prepared. Specific Instruments and materials are readied for your visit in a room that is reserved for your particular needs. We ask that if you must change an appointment, to please give us at least 48 hours notice. This courtesy makes it possible for us to prepare for another patient.

There is a charge for not showing up or canceling your scheduled appointment without 48 hour notice. Repeated cancellations or missed appointments will result in loss of future appointment privileges. We feel that our patient's time is extremely valuable. Except for rare emergency treatment of another patient, you can expect us to be prompt. We, of course, always appreciate the same courtesy in return.

_____ _____ _____

Signature Print Name date

FINANCIAL & INSURANCE

As health care providers, our professional doctor-patient relationship is with you, not your insurance company. All charges for services become your responsibility from the date services are rendered. Insurance limits and benefits are determined by your employer or private health insurance plan. We will advise you on the treatment options based on your own individual needs for preventative and restorative treatment and not based on what your insurance company may cover. However, if you have dental Insurance benefits, we will gladly help you receive your maximum allowable coverage towards any proposed treatment. Our office manager will discuss your treatment plan, estimated co-pays and answer any questions relating to your insurance and payment options.

Our office is a fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Visa or Master Card to automatically cover amounts not paid by your insurance.

We offer the following payment options:
Cash
Check
Visa/Master Card
Care Credit (up to 6 months interest free financing)
Automatic debit/credit card on file for charges not covered by insurance

I understand and I agree to pay all charges or estimated co-pays at the time of service. All charges for services billed to my insurance company are my responsibility. Any account balance not paid within 30 days is considered delinquent. Delinquent accounts are subject to financing charges, collections or other legal action.

_____ _____ _____

Signature Print Name date