PS Dental
Parisa Sepehri, DDS

"Your Smile is Our Passion"

Patient Information:

Date: _______________

Name: ____ DOB:_____________ Age: _______ M / F
Last First MI

Minor ______ Single ______ Married _______ Divorced _____ Widowed ______ Separated _____ Other _______

If minor - Who is responsible for this account?: ______________________ Relationship:_____________________

Responsible Party Information:

SS#: ______/______/______ DL#: _________________State____ Email: ______________@____________.com

Home Phone: ____________________ Cell Phone: _____________________ Work Phone: ____________________

What is your preferred method of contact? ____

Address: ___________________________________City: ______________________St: _______ Zip: ________

Employer Name: _____________________ Occupation: ______________ All right to call at work? Y / N

Person to contact in case of Emergency? : ________________ Relationship: ____________Phone: _____________

Insurance Information:

Primary Insurance:

Subscriber: ______________________________ DOB: _____________ SS/ID ________________________

Insurance: ___________________________ Group: ___________________ ID: _______________________

Employer:___ _________________________________ Phone: _____________________________________

Secondary Insurance:

Subscriber: ______________________________ DOB: _____________SS/ID: ________________________

Employer: ____ Phone #: ___________________________

Insurance: ___________________________ Group: ___________________ ID: _______________________

*Payment is expected at the time of service. We offer the following methods of payment: VISA, Master Charge, American Express, DISCOVER, debit cards, Care Credit and cash. We also offer cash discounts for our uninsured patients who are 60+ years of age or who have served our country, our Veterans.
*Thank you for your patronage.

____ ______________________________

Patient or Responsible Party Date

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Dental and Health History

Name: ____ Sex: ________ Birth date: ____________________

Primary Care Doctor: ____ Dr. Phone: ____________________
First Name Last Name

Dr. Address: ____ City: __________________ Zip: ______________

Previous hospitalizations/surgery/serious illnesses? ____

____

Have you ever taken the medication Fosamax? Y / N

Are you currently taking any medication? Please list medication and purpose.

Medication	Purpose	Medication	Purpose
1.________________________	________________	4.______________________________	________________
2.________________________	________________	5.______________________________	________________
3.________________________	________________	6.______________________________	________________

Do you have a history of allergies/sensitivities/adverse reactions to any drugs or medications? Y / N
If yes please describe. ____
____

Do you have allergies to latex or other substances? ____
History of smoking? Y / N History of use of chewing tobacco? Y / N
Have you ever been diagnosed with SLEEP APNEA? Y / N

DO YOU HAVE OR HAVE YOU HAD IN THE PAST:

Y	N		Y	N	
___	___	Stroke	___	___	Rheumatic Fever
___	___	Cancer	___	___	Epilepsy/Seizures
___	___	Anemia	___	___	Fainting/Dizziness
___	___	Asthma	___	___	Radiation Therapy
___	___	Arthritis	___	___	High Blood Pressure
___	___	Diabetes	___	___	Psychiatric Treatment
___	___	Hepatitis	___	___	Congenital Heart Defect
___	___	HIV/AIDS	___	___	Congestive Heart Failure
___	___	Headaches	___	___	Recreational or street drugs
___	___	Tuberculosis	___	___	Other/Hospitalizations: ______________
___	___	Heart Murmur	___	___	Handicaps/disabilities - Diagnosis: ____________
___	___	Ear Problems			
___	___	Liver Disease			
___	___	Blood Disease			FOR WOMEN ONLY:
___	___	Kidney Disease	___	___	Do you take birth control medication?
			___	___	Are you/or are you trying to become pregnant?

___ ___ Do you have a family history of diseases? If so please explain: ____

____

Previous dentist: ______________________________________ Date of last visit : ____________________________________

How often do you brush? __________________________________ How often do you floss? ______________________________

Do you have any dental concerns or problems? ____

AUTHORIZATION & RELEASE: To the best of my knowledge the questions on this form have been accurately answered. I authorize Parisa Sepehri, DDS, to release any information of my dental treatment and diagnosis to my insurance company. I also authorize and request my insurance company to pay directly to the Dentist benefits otherwise payable to me.

____ ____
Patient or Responsible Party Date

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PAYMENT POLICY ACKNOWLEDGMENT

We are committed to providing you with the best possible dental care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policies.

Payment Options:

- **5% savings** on **uninsured** treatment, paid-in-full at the time of treatment.
- **Additional 5%** for our senior patients age 55 and up, 10% total.
- **Additional 5**% for service men and women, 10% total.
- We accept the following major credit cards: **VISA, MC, DISCOVER** and **AMERICAN EXPRESS**.
- For those who desire a payment plan, we are partnered with **CareCredit**. This payment plan is based on your approved credit. There are no application fees. These arrangements must be made **prior** to treatment.

Insurance:

Payment of your deductible and the estimated portion your insurance does not cover are expected at the time of treatment. We will provide insurance billing as a service to you**.** However, **if there is no payment from your insurance company in our office within 45 days, you are responsible for the balance in full at that time. Any balances unpaid after 60 days will be subject to interest equal to 1.5% per month.** Your insurance policy is a contract between you and that insurance company. We are not able to negotiate with your insurance company on your behalf**. Balances over 90 days will be sent to collections and assessed a $50.00 fee. Any checks returned to our office for NSF(non-sufficient funds) will incur a $25.00 fee.**

Usual and Customary Rates:

We charge what is usual and customary for our area. Please be aware that some of the services we provide **may not be covered services by your dental plan**. You are responsible for payment regardless of your insurance company's exclusions and fee schedules.

Missed Appointments:

When you schedule an appointment we reserve that time especially for you. If you are late or do not arrive we cannot provide your needed treatment. The staff does not have a person to serve, therefore we reserve the right to charge for appointments cancelled or missed without 2 business days' notice. **Our missed appointment fee is $75.** Multiple missed appointments or short notice cancellations will result in an end of our ability to successfully provide you with ongoing dental care.

Minor Patients:

If a minor is not accompanied by their parents/guardian, arrangements for payment need to be made prior to the appointment.

I have read the Payment Policy Acknowledgment and understand that I am responsible for any balances, regardless of insurance coverage, and that a finance charge of 1.5% will be applied, per month, to any balances over 30 days or more. I authorize PS Dental to submit charges to my credit card to cover balance over 30 days or more.

Credit card on file:

VISA / MC / DIS /AMEX / CareCredit: ________ - _________ - _________ - ________ Exp ______ /_______

Patient or Responsible Party_______________________________________ **Date:** ______________________

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AESTHETIC QUESTIONNAIRE

To aid in our diagnosis and treatment of your aesthetic concerns, please take a moment and answer the following questions. Please circle your answer.

Do you dislike the color of your teeth?	YES	NO
Do you have spaces between your teeth that bother you?	YES	NO
Do you have chips or uneven edges on your teeth?	YES	NO
Do you feel that your teeth are too long or too short?	YES	NO
Do you have dark fillings that show when you smile?	YES	NO
Do your gums show too much when you smile?	YES	NO
Are your teeth crowded or crooked?	YES	NO
Do you have existing crowns or dental work that you consider ugly?	YES	NO
Are you self-conscious of your teeth and/or smile?	YES	NO
Has anyone ever suggested that you Should have something done with your teeth or smile?	YES	NO
Do you avoid smiling when you have your picture taken?	YES	NO
Would you like to improve your existing smile?	YES	NO
Do you wish you had a "new smile"?	YES	NO

What concerns do you have regarding dental treatment to improve your smile?

- □ Embarrassment
- □ Fear of treatment
- □ Distance to office
- □ Financial concerns
- □ Time of treatment concerns
- □ Not understanding treatment
- □ Other (please explain)

____

____

____

PS Dental Services
Parisa Sepehri DDS

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement. **

I, ____,
(Please print Patient's name)

have received a copy of this office's Notice of Privacy Practices.

____

Signature of Responsible Person Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign.

[ ] Communication barriers prohibited obtaining the acknowledgement.

[ ] An emergency situation prevented us from obtaining acknowledgement.

[ ] Other (Please Specify)

____
____
____
____