Drs. Bonahoom & Ghafourpour **1291 E. HILLSDALE BLVD., SUITE 110 • FOSTER CITY, CA 94404 • (650)574-3611**

PATIENT FIRST NAME _____ **LAST NAME** _____

PATIENT IS ☐ POLICY HOLDER ☐ RESPONSIBLE PARTY PREFERRED NAME _____

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

FIRST NAME _____ LAST NAME _____ M.I. _____

ADDRESS _____ CITY/STATE/ZIP _____

PHONE NUMBERS (CHECK BOX OF PREFERRED NUMBER) HOME ☐ _____ WORK ☐ _____

CELL ☐ _____ BIRTH DATE _____ SOC.SEC. _____

PATIENT INFORMATION

ADDRESS _____ CITY/STATE/ZIP _____

PHONE NUMBERS (CHECK BOX OF PREFERRED NUMBER) HOME ☐ _____ WORK ☐ _____

CELL ☐ _____ BIRTH DATE _____ SOC.SEC. _____

SEX ☐ MALE ☐ FEMALE STUDENT ☐ FULL TIME ☐ PART TIME SCHOOL _____ CITY/ST _____

EMPLOYED ☐ FULL TIME PART TIME EMAIL ADDRESS _____ ☐ OK TO USE EMAIL ☐ NO

REFERRED BY _____

PRIMARY INSURANCE COVERAGE

NAME OF INSURED _____ BIRTH DATE _____

SOC.SEC. _____ RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER _____

EMPLOYER _____ INS. COMPANY _____

ADDRESS _____ ADDRESS _____

ADDRESS 2 _____ ADDRESS 2 _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

GROUP NUMBER _____ ID NUMBER _____ UNION OR LOCAL _____

SECONDARY INSURANCE COVERAGE

NAME OF INSURED _____ BIRTH DATE _____

SOC.SEC. _____ RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

EMPLOYER _____ INS. COMPANY _____

ADDRESS _____ ADDRESS _____

ADDRESS 2 _____ ADDRESS 2 _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

GROUP NUMBER _____ ID NUMBER _____ UNION OR LOCAL _____

FINANCIAL POLICY AND PAYMENT AUTHORIZATION

PAYMENT IS EXPECTED IN FULL AT TIME OF SERVICE. THIS OFFICE WILL SUBMIT INSURANCE CLAIMS ON BEHALF OF THE PATIENT, HOWEVER, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF BILL. I AUTHORIZE PAYMENT DIRECTLY TO DR. GHAFOURPOUR OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL CARE INSURANCE CARRIER OR PAYOR OF MY DENTAL BENEFITS MAY PAY LESS THAN THE ACTUAL BILL OR ESTIMATE FOR SERVICES AND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL OF ALL ACCOUNTS. BY SIGNING THIS STATEMENT, I REVOKE ALL PREVIOUS AGREEMENTS TO THE CONTRARY AND AGREE TO BE RESPONSIBLE FOR PAYMENT OF SERVICES NOT PAID BY MY DENTAL CARE PAYOR.

I ATTEST TO THE ACCURACY OF THE INFORMATION ON THIS PAGE.

PATIENT OR GUARDIAN'S SIGNATURE

_____

DATE _____

CONSENT TO TREATMENT AND DISCLOSURE / DMFS RECEIPT

I CONSENT TO THE DIAGNOSTIC PROCEDURES AND TREATMENT BY THE DENTIST NECESSARY FOR PROPER DENTAL CARE. I CONSENT TO THE DENTIST'S USE OF MY RECORDS (OR MY CHILD'S RECORDS) TO CARRY OUT TREATMENT, TO OBTAIN PAYMENT, AND FOR THOSE ACTIVITIES AND HEALTH CARE OPERATIONS THAT ARE RELATED TO TREATMENT OR PAYMENT. I CONSENT TO THE DISCLOSURE OF MY RECORDS (OR MY CHILD'S RECORDS) TO THE FOLLOWING PERSONS WHO ARE INVOLVED IN MY CARE (OR MY CHILD'S CARE) OR PAYMENT FOR THAT CARE:

_____

_____

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THE DENTAL MATERIALS FACT SHEET FROM Drs. Bonahoom & Ghafourpour (CHECK BOX IF YES) ☐

PATIENT OR GUARDIAN'S SIGNATURE

_____

DATE _____

Patient Name: _____

DENTAL INFORMATION

Purpose of initial visit _____

How long since you've seen a dentist? _____ Since your teeth were cleaned? _____

Previous dentist's name: _____ Phone: _____

Address: _____

Do you clench or grind your teeth? Y☐ N☐ If yes, explain _____

Does your jaw click or pop? Y☐ N☐ If yes, explain _____

Any other dental problem? Y☐ N☐ If yes, explain _____

MEDICAL INFORMATION

Physician's Name: _____ Phone: _____

Address: _____ City, State: _____

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

Do you take or have you taken:

Boniva (Oral) Y☐ N☐ Actonel (Oral) Y☐ N☐ Fosamax (Oral) Y☐ N☐ Aredia (i.v.) Y☐ N☐ Zometa (i.v.) Y☐ N☐

Any other Osteoporosis medication not listed above Y☐ N☐ Name of Medication _____ If yes to any of these, date last taken _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____