

Dear Patient,

It is with great pleasure that we welcome you to our dental practice at North County Dental Care and Orthodontics. We want you to know that we appreciate the opportunity to take care of you and your family. Our dental team, lead by Dr. Edward Adourian, is very proud of the full line of dental services and products that we offer in our multi-specialty office, all with the sole purpose of providing you with high quality and gentle dental care.

During your first visit, the doctor will examine your teeth, perform an oral cancer exam, take necessary digital x-rays, and make an assessment of your oral condition. Staff members will assist the doctor on completing your dental health evaluation and you will be meeting several members of our dental team. If it is discovered that you need any dental treatment, a treatment plan and estimate will be prepared for you prior to the beginning of any procedure. You will have the opportunity to review the recommended treatment plan and ask questions, which we will be happy to answer in detail.

Please fill out the New Patient Packet which will give our team the information needed to provide you with the best dental care. Also please read and sign forms that provide you with important information to help you make informed decisions about your dental health care.

If you have dental insurance, we will need to have a copy of your insurance card. We also ask you to always notify us of any changes in your dental insurance coverage so we can update your records. If you are unsure about the type of dental insurance you have, our staff will be happy to assist you in obtaining and understanding your benefits.

Thank you again for choosing our office. We are looking forward to taking care of you today and in the future. Enjoy your visit and welcome to our office.

Sincerely,

Dr. Edward Adourian

PLEASE FILL THIS FORM OUT COMPLETELY

Date _____ Patient's Name _____ Spouse _____

Last First Middle

Address _____ Birthdate ___/___/___

Street City State Zip

Home Phone (____) _____ Cell Phone(____) _____ Work Phone (____) _____

Social Security _____ Drivers License # _____ Email _____

Emergency Contact _____ Relationship to patient _____ Phone (____) _____

How did you hear about our office?

- Yelp Sign Insurance Internet Friend Family Member Phone Book Flyer

HOW WOULD YOU LIKE TO BE CONTACTED?

- Phone Call Text Email

Responsible Party (Accompanying Parent/Guardian)

Name _____ Phone (____) _____

Last First Middle

Residence _____

Street City State Zip

Social Security _____ Birthdate ___/___/___ Relationship to patient _____

Employer _____ Phone (____) _____

INSURANCE INFORMATION

As a courtesy to our patients, we file your dental insurance claim. Dental insurance is not like medical coverage and rarely covers the same percentage. Your dental insurance is a contract between you or your employer and your insurance company for your benefit. The professional treatment and dental services offered by North County Dental Care & Orthodontics and your dental insurance are for your best oral health and will not be dictated by insurance coverage.

You are responsible for the deductible and percentage not covered by insurance for the work performed by North County Dental Care & Orthodontics on the day of service. We have many payment options available at any time to discuss the best option for you.

We file many of our claims electronically therefore, a signature on file is required by all dental insurance companies. We must have a filled out insurance form to submit an insurance claim for you.

We will always do our best to help you maximize you dental benefits, however, ultimate responsibility for payment is yours and financial arrangements must be defined prior to beginning dental treatment.

Insured's Name _____ Insured's Birthday ___/___/___ SSN or ID# _____

Insurance Company _____ Phone # _____ Group# _____

Employer _____

Do you have dual coverage? ____YES____NO If yes, please complete the following secondary information:

Insured's Name _____ Insured's Birthday ___/___/___ SSN or ID# _____

Insurance Company _____ Phone # _____ Group# _____

PATIENT NAME: _____

MEDICAL DOCTOR'S NAME: _____ Phone No: _____ City: _____

If no physician, please initial _____

1. Have you ever or are you currently taking Bisphosphonates for osteoporosis, myeloma or other cancers (reclast, fosamax, actonel, bonival, aredia zomets)? Yes No

2. Are you now taking any medications or drugs? Yes No
If yes, please specify: _____

3. Are you sensitive or allergic to any medication or anesthetics? Yes No
If yes, check: Penicillin Tetracycline Sulfa Drugs Aspirin Codeine Latex Other: _____

4. Have you ever had Appetite Suppressant in the past? Yes No

5. Indicate which of the following you have had or have at present. Check 'yes' or 'no' to each item.

- | | | | |
|--------------------------|--|---|--|
| Heart Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Joints / Prosthetic Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy to Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease or Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis (Serum) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Developmentally Disabled | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina Pectoris | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breast Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | A.I.D.S | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arteriosclerosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies or Hives | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting or Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervousness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Type_____ |
| Tumor | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

6. Do you have or have had any disease, condition, or problem not listed? Yes No

If yes, please list: _____

7. Are you pregnant? Yes No If yes, what month? _____

Are you nursing? Yes No

Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

For Office Use Only Reviewed by Dr. _____ Date _____

Dr _____	Pt _____	Date _____	Dr _____	Pt _____	Date _____
Dr _____	Pt _____	Date _____	Dr _____	Pt _____	Date _____
Dr _____	Pt _____	Date _____	Dr _____	Pt _____	Date _____
Dr _____	Pt _____	Date _____	Dr _____	Pt _____	Date _____

Circle one:

I prefer: to learn every detail of my care OR just an overall explanation

I prefer: long-lasting solutions OR temporary low cost solutions

I prefer: to let my insurance coverage control my care OR to let my dentist determine my dental needs

What is your main concern regarding your teeth?

Have you ever been advised that you have periodontal problems (gum infection)?

Are there things that you would like to change about your smile?

Are you interested in getting your teeth whitened, if it is affordable?

Have you ever had orthodontics in the past?

Do you have a concern regarding silver mercury fillings?

Are you a high fear patient, and would you be interested in sedation?

Is there anything that you would like the doctor to address?

Are you having pain or discomfort at this time? Yes No

Explain: _____

Do your gums bleed when you brush? Yes No

Do you grind or clench your teeth? Yes No

Do you have any fear of dental work? Yes No

Are your teeth sensitive to heat or cold? Yes No

Pressure? Yes No

Sweets? Yes No

Do you smoke? Yes No

If yes, how much per day? _____

Do you drink alcohol? Yes No

If yes, how much daily? _____

Date of last dental examination? _____

What was done at the time? _____

How would you describe your current dental problem? _____

I am interested in: teeth whitening cosmetic evaluation replacement of mercury sedation

white fillings home care other: _____

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complication.
2. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service. In the event payments are not received by agreed upon dates, you understand that a monthly 1.5% late charge may be added to your account. I also understand that any returned checks or insufficient payments will be assessed a \$25 fee and the entire balance will be required to be paid immediately. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, cost, expense and court cost incurred in the collection.
3. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment to the dentist or dental practice to be applied directly to any outstanding balance on my account.
4. I understand if I cancel an appointment with less than 24 hour notice, there may be a failed appointment fee which I agree to pay before any further appointments can be made.
5. By signing this agreement, you give consent to the doctor's or designated staff to use and disclose any oral, written or electronic health records that are individually identifiable as the patient's for the purpose of carrying out treatment, payment and health care operations.
6. I acknowledge that I have reviewed the CDA Notice of Privacy Practices on www.ncdentalcare.com and can get a copy upon request.
7. I grant my permission to you or your assignee, to telephone me to discuss this statement, my account, appointments or my treatment, or to discuss with the person listed below.

Name: _____ Relationship to Patient: _____

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Patient Name: _____

Signature Patient/Guardian Date

Relationship to Patient