PAUL VARTABEDIAN, DDS
Prosthetic, Cosmetic & Implant Dentistry
YOUR SMILE. OUR PASSION.

PATIENT INFORMATION

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Gender: M/F Family Status: Married/Single/Child/Other Date of Birth: _____

SS#_____-_____-_____ Email Address: _____

Home phone: _____ Mobile phone: _____ Work phone: _____

Address: _____ _____
Mailing Physical- if different

_____ _____ _____
City State Zip Code

Whom may we thank for referring you to our practice? _____

Emergency Contact: _____ Phone number: _____

(PARENT/LEGAL GUARDIAN ACCOMPANYING MINOR)

First Name: _____ Last Name: _____ Relation to Patient: _____

Date of Birth: _____ SS#_____-_____-_____ Employer: _____

Address: _____ City, State, Zip _____

Home phone: _____ Mobile phone: _____ Work phone: _____

HIPAA Acknowledgement

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health information (PHI) for the purposes of treatment, payment, and health care operations as described in the Privacy Notice (Health Insurance Portability & Accountability Act)

Signature: _____ **Date:** _____

Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other (specify) _____

Apart from your insurance and treating physicians, HIPAA restricts us from disclosing information to ANYONE without your written consent. If you wish to authorize release of information to someone (parent, spouse, child, friend, etc.) please let us know:

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient Name: _____ _____
Last First

CONSENT (please initial below):

_____ I authorize the doctor and staff to perform any dental treatment mutually agreed upon, with the use of the agreed upon anesthetics and/or medications if necessary. I fully understand the risks/benefits/alternatives to treatment provided, and can discuss these at any time before, during, and/or after treatment. I have reviewed and can request a copy of the "Notice of Privacy Practices Sheet" and "Facts about Fillings Sheet." I can ask questions at any time regarding this information. The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my/my child's physician.

_____ I authorize the doctor and staff to request my records from my previous dental/specialist offices, if needed.

_____ I understand that **payment is due at the time of service**, and if payment is not received by agreed upon dates, I will be responsible for any finance charges accrued. For dental insurance Dr. Vartabedian is a provider for, I authorize and request my insurance company to pay directly to the dentist otherwise payable by me. I agree to be responsible for any costs not paid by insurance. **I understand that if Dr. Vartabedian is not an in-network provider for my dental insurance, I will be responsible for paying the full amount of services rendered at the time of service. As a courtesy to me, they will bill my dental insurance and I will receive payment from my dental insurance directly.** The costs estimates I am given are only estimates and unforeseen events may cause a change in the cost for my treatment.

_____ I understand the appointments I schedule are held for me. Should I need to cancel or reschedule, I understand that I need to give notice **7 DAYS prior** to appointments for non-preventative procedures or **3 DAYS prior** to preventative appointments (check-up exams, xrays, dental cleanings). **A broken-appointment fee of up to 50% of the treatment amount scheduled** for any appointment missed or cancelled without the **above-required** notification may be applied.

By signing below, I understand and agree to the terms above.

Patient/Guardian Signature: _____ **Date:** _____

PRIMARY INSURANCE: Please enter *Subscriber* Information below:

First Name: _____ Last Name: _____ Relation to Patient: _____

Date of Birth: _____ SS#_____-_____-_____ Employer: _____

Insurance Company Name: _____ Insurance Phone Number: _____

SECONDARY INSURANCE (if applicable): Please enter *Subscriber* Information below:

First Name: _____ Last Name: _____ Relation to Patient: _____

Date of Birth: _____ SS#_____-_____-_____ Employer: _____

Insurance Company Name: _____ Insurance Phone Number: _____

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MEDICAL INFORMATION

Patient Name: _____

Physician Name: _____ City: _____ Phone: _____

Date of most recent physical exam: _____ **Pharmacy:** _____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Acid Reflux Disease	☐ Allergies / Hives	☐ Allergy: Codeine	☐ Allergy: Iodine
☐ Allergy: Latex	☐ Allergy: Penicillin	☐ Allergy: Septra	☐ Allergy: Sulfa
☐ Allergy:Hydrocodone	☐ Allergy:Tetracycline	☐ Angina Pectoris	☐ Anxiety
☐ Arthritis	☐ Artificial Joints	☐ Asthma	☐ Autoimmune Disorder
☐ Blood Disorder	☐ Blood thinners	☐ Blood Transfusion	☐ Cancer- head/neck
☐ Cancer	☐ Chemotherapy	☐ Chronic Cough	☐ Cold Sores
☐ Coumadin Therapy	☐ Diabetes	☐ Dizziness / Fainting	☐ Dry mouth
☐ Emphysema	☐ Epilepsy	☐ Epinephrine Sens	☐ Hay Fever
☐ Heart Disease	☐ Heart Murmur	☐ Heart Valve Surgery	☐ Hepatitis A
☐ Hepatitis B	☐ Hepatitis C	☐ High Blood Pressure	☐ HIV
☐ Kidney Trouble	☐ Liver Disease	☐ Lupus	☐ Mental Disorders
☐ Mitral Valve Prolaps	☐ Neuro Disorder	☐ Osteoperosis meds	☐ Other
☐ Pacemaker	☐ Physical Disability	☐ Pregnancy	☐ Premed - Not Needed
☐ Premed	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Seizure Disorder	☐ Sinus Problems	☐ Stroke	☐ Thyroid Disease
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

☐ Ever been hospitalized (illness or injury)	☐ Presently being treated for any other illnesses
☐ A smoker or smoked previously	☐ History of chewing tobacco
☐ FEMALE: Taking birth control pills	☐ FEMALE: Pregnant

If any conditions/alerts selected above need further clarification or you have conditions not listed above, please describe below:

_____

Covid-19 vaccinated: YES NO

Current medications: _____

_____

Have you ever taken Bisphosphonates (Fosamax, Reclast, Boniva, Didronel, Actonel, Aclasta, Aredia, Atelvia, Skelid, Zometa)? YES NO If yes, please list medication _____

Do you take antibiotic premedication for your dental visits? YES NO

If yes, what medication and for what reason? _____

Patient/Guardian Signature: _____ **Date:** _____

Dentist: _____ **Date reviewed:** _____ **BP/Pulse:** _____

Patient Name: _____

Previous Dentist name and reason for leaving: _____

Date of last dental cleaning: _____ Date of last xrays: _____ Brush: ____/day Floss: ____/day

Toothbrush: manual/electric

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)

Personal Dental History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Had periodontal treatment (gum surgery, root planing)
☐ Had any teeth removed
☐ Feel nervous about having dental treatment
☐ Had trouble getting numb
☐ Had/have braces, orthodontic treatment
☐ Had your bite adjusted

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?
☐ Have you ever whitened (bleached) your teeth?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint
☐ You have problems chewing
☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
☐ Your teeth are crowding or developing spaces
☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
☐ You clench your teeth in the day or night
☐ You have problems with sleep or wake up with an awareness of your teeth, tired jaws
☐ You have clicking or popping of the jaw
☐ Your jaw has locked open or closed
☐ You have pain in the jaw joint, ear, or side of face
☐ You have or had a bite appliance (night guard)

Tooth structure, Check all that apply:

☐ Cavities within past 3 years
☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
☐ You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
☐ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
☐ Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
☐ Food gets caught between any teeth

Gum and Bone, Check all that apply:

☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ History of periodontal disease in your family
☐ Experienced gum recession
☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple
☐ Experienced a burning sensation in your mouth