



Victor K. Muradian, DDS

WELCOME

Please take few minutes to fill out this form as completely as you can. Also please review and complete the Office Policy form. If you have any question, we will be glad to help.

Name _____	Preferred Name _____	
First Middle Last		
Birthdate _____	Drivers Lic. # _____	Social Security # _____
Home Phone _____	Cell Phone _____	e-mail _____
Address _____	City _____	Zip _____
Employer _____	Occupation _____	
Employer Address _____	Work phone _____	
Who may we thank for referring you _____		
Contact in case of emergency _____	Phone _____	

Who is financially responsible for this account _____	Relationship _____
Address: _____	Phone _____
Social Security or Dental Insurance ID _____	Primary Insurance _____
Secondary Insurance _____	Name of Insured _____

Dental History	
1. Purpose of this visit _____	
2. How long since last dental visit? _____	Date of last dental Xrays _____
3. Have you had any allergic reaction from dental treatment? _____	Explain? _____
4. Do you clench or grind your teeth? _____	When? _____
5. Have you experienced problems in your jaw? _____	<input type="checkbox"/> Clicking <input type="checkbox"/> Popping <input type="checkbox"/> Pain
6. Have you experienced any soreness or lumps in your face/mouth? _____	Where? _____
7. Does food get caught in your teeth? _____	Where? _____
8. Are you sensitive to: <input type="checkbox"/> Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets <input type="checkbox"/> Chewing <input type="checkbox"/> Pressure	
9. Do your gums bleed or hurt? _____	When? _____
10. How often do you Brush? _____	Floss? _____
11. Have you had gum surgery? _____	When? _____ Where? _____
12. Are your teeth: <input type="checkbox"/> Loose <input type="checkbox"/> Shifted <input type="checkbox"/> Chipped <input type="checkbox"/> Cracked <input type="checkbox"/> Discolored	
13. Do you snore or have difficulty sleeping? _____	Explain _____
14. Do you play high contact sports? _____	If yes, do you wear a mouth guard? _____
15. Are you unhappy with your past dental treatment? _____	Explain _____
16. Are there old fillings or dental work that you don't like? _____	Explain _____
17. Are you unhappy with the appearance of your smile? _____	Why? _____
18. What would you like to change the most in the appearance of your smile? _____	

Dr. Muradian's Office Policy

Time Commitment

A scheduled appointment is a commitment of time between you and our doctor/hygienist. We reserve that time just for you. When an appointment is missed or canceled on short notice that time is lost instead of being used by another patient. We make every effort to honor all time commitments and we request of you to extend the same courtesy to us.

Our office usually confirms appointment 48 hours in advance. Please advise the office if you need to change your appointment at that time. We reserve the right to charge \$100 for appointments missed or canceled without a 24 hours prior notice.

Dental Insurance

We are happy to bill your dental insurance carriers, except for Denti-Cal and HMO type, on your behalf at no charge. The benefits that are actually paid by insurance carriers vary widely from carrier to carrier and group to group and depend primarily on the benefits negotiated and paid for by your employer, union, or other group with the insurance carrier. Very often we can provide you with an approximate estimate of your coverage prior to treatment. However, we can not guarantee the insurance payment as estimated. Hence, **any treatment rendered to you will be your financial responsibility irrespective of what your insurance pays.** With your signature (below) you accept our policy and authorize Victor K. Muradian, DDS to 1) bill your insurance carriers on your behalf; 2) release any information regarding treatment at this office to your insurance carriers; 3) authorize payment directly to Victor K. Muradian, DDS any insurance benefits due to services rendered.

Payment in Full

Payment is required on the day of your appointment. If you have dental insurance, your estimated co-payment and deductible are due on that day.

Payment Options

For your convenience, we accept cash, check and all major credit cards (Visa, MasterCard, American Express and Discover). Furthermore, our office offers easy to use financing programs through several finance companies. One of our programs offers a 12 months same as cash option and no penalty for early payoff. You may use our finance program for all or part of your procedure (over \$1000).

How do you plan to pay for your portion of the treatment?

Cash Check Credit Card Finance program

Notice of Privacy Practices

Our office obeys federal and state law regarding the privacy of your health information. With you signature below you Acknowledge the Receipt of our office's Notice of Privacy Practices (you may refuse to Sign This Acknowledgment).

Dental Material Fact Sheet

The Dental Board of California has prepared a fact sheet to summarize information on the most frequently used restorative dental materials. We encourage you to discuss its content with Dr. Muradian. With your signature below you acknowledge receiving a copy of the Dental Material Fact Sheet.

Patient/Guardian name _____ Signature _____ Date _____

Insurance Information

If you have dental insurance, other than HMO or Denti-Cal, we are happy to bill any of your dental insurance carriers on your behalf at no charge. The benefits that are actually paid by insurance carriers vary widely from carrier to carrier and group to group and depend primarily on the benefits negotiated and paid for by your employer, union, or other group with the insurance carrier. Additional factors such as the cost of the policy, the date its terms were negotiated, cost of living increases, table of allowances, deductibles, other dental work done during the policy year, etc. also affect the amount of benefits you receive. Because of these variables beyond our control, we do not render services based on what your insurance will pay. If any professional services are rendered to you, you are financially responsible for the services rendered, irrespective of what your insurance pays. If you have any questions about our policies, our staff will be pleased to answer them. Very often we can provide you with an approximate estimate of your coverage prior to treatment based on our general experience with insurance carriers or with your insurance carrier in particular. However, if you need to know the exact amount the benefits paid by insurance carrier, you will need to contact your insurance carrier directly. If they require predetermination of benefits to provide the information, we will complete the necessary paperwork and send it to your carrier for you, again at no charge. If you agree to these terms, please complete the following information and we will bill your insurance carrier(s) for you.

Primary Dental Insurance Policyholder Information

Policyholder Name _____ Soc Sec or ID # _____
Birthdate _____ Relationship to Patient: Self Spouse Child Other _____
Employer _____ Phone _____
Group # _____ Policy # _____
Insurance Carrier _____ Customer Service Phone _____

If you have a **Secondary Dental Insurance** and you would like us to bill that insurance carrier for you also, we will need the following information:

Policyholder Name _____ Soc Sec or ID # _____
Birthdate _____ Relationship to Patient: Self Spouse Child Other _____
Employer _____ Phone _____
Group # _____ Policy # _____
Insurance Carrier _____ Customer Service Phone _____

I understand the office policies regarding my insurance coverage(s) and authorize Victor K. Muradian, D.D.S. to 1) bill my insurance carrier(s) on my behalf; 2) release any information regarding my treatment at this office to my insurance carrier; 3) authorize payment directly to Victor K. Muradian, D.D.S. any insurance benefits otherwise payable to me. I know that I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is a valid as original.

Signature patient or guardian _____ Date _____