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? _____ ☐ Clicking ☐ Popping ☐ 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: ☐ Hot ☐ Cold ☐ Sweets ☐ Chewing ☐ 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: ☐ Loose ☐ Shifted ☐ Chipped ☐ Cracked ☐ 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? _____
    _____

Medical History

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Circle **Yes** or **No** where applicable.

1. Are you in good health……Yes No
2. Are you under the care of a physician?……Yes No
   If so, what is the condition(s) being treated?_____
   _____
3. Physician name_____ Date of last physical exam_____
   Address_____Phone#_____
4. Have you ever had any serious illness or operation?……...Yes No
   If so, what illness or operation?_____
5. Have you ever been hospitalized?……Yes No
   If so, what was the problem?_____
6. Are you taking any medicine?……..Yes No
   If so what? and how much?_____
   _____
7. Are you taken any recreational drugs (marijuana, cocaine, etc.)?……Yes No
   Please note that some recreational drugs taken within 24 hours of dental treatment could be fatal.
8. Have you ever been pre-medicated with antibiotics for your dental treatment?……Yes No
9. Are you sensitive or allergic to any drugs? ☐Penicillin ☐Sulfa Drugs ☐Aspirin ☐Codeine ☐Other If other, What drugs?_____
10. Do you have **or have had** any of the following:

	Y	N		Y	N		Y	N		Y	N
Anemia	☐	☐	Heart Murmur	☐	☐	Recent Weight Loss	☐	☐	Thyroid Disease	☐	☐
Hemophilia	☐	☐	Angina/Chest Pains	☐	☐	Epilepsy/Seizure	☐	☐	Cerebral Palsy	☐	☐
Rheumatism	☐	☐	Heart Failure	☐	☐	Nervous Disorder	☐	☐	Blood Transfusion	☐	☐
Scarlet Fever	☐	☐	High Blood Pressure	☐	☐	Respiratory Disease	☐	☐	Excess. Bleeding	☐	☐
Diabetes	☐	☐	Mitral Valve Prolapse	☐	☐	Turberculosis TB	☐	☐	Blood Diseases	☐	☐
Glaucoma	☐	☐	Congenital Heart Problems	☐	☐	Emphysema	☐	☐	Latex Allergy	☐	☐
Arthritis	☐	☐	Hepatitis/Jaundice	☐	☐	Asthma	☐	☐	Smoke	☐	☐
Cancer	☐	☐	Liver Disease	☐	☐	Sinus Troubles	☐	☐	Chew Tobacco	☐	☐
Ulcers	☐	☐	Kidney Disease	☐	☐	Venereal Diseases	☐	☐	Drug Addiction	☐	☐
Hay Fever	☐	☐	Joint Replacement	☐	☐	Fainting Spells	☐	☐	Cortisone Med.	☐	☐
Cold Sore	☐	☐	Artificial Prosthesis	☐	☐	Chemotherapy	☐	☐	Phen Fen/Redux	☐	☐
Stroke	☐	☐	Head Injuries	☐	☐	Radiation Treatment	☐	☐	AIDS/HIV	☐	☐
Heart Attack	☐	☐	Mental Disorder	☐	☐	Rheumatic Fever	☐	☐	Others	☐	☐

11. Do you wear a cardiac pacemaker, or have you had heart surgery?…..……Yes No
12. Do you have any conditions or problems not listed that you think I should know about?…….Yes No
    If yes, explain_____

(Women) Are you pregnant?.☐Y..☐N Nursing? ☐Y..☐N Taking birth control?.☐Y..☐N

I certify that the above information is complete and accurate. If any changes occur to my health I will advise the office immediately. I understand that I am responsible for full payment of each procedure at, or prior to, the time of treatment. I agree to give a 24 hours notice if I change an appointment. I grant permission to Victor K. Muradian, D.D.S. to take any necessary x-rays, administer anesthetics, and to employ such operative and technical procedures as necessary or advisable for the diagnosis and treatment of the above patient. All records, including photographs, are the property of the office.

Signed_____Date_____
Patient Guardian

Reviewed by _____Date_____

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_____