**BAKER RANCH DENTAL SPA & IMPLANT CENTER**
**KHOSHSAR RAMIN DMD , DDS**
CREATIVITY • INTEGRITY • PASSION • TALENT

WWW.BAKERRANCHDENTISTRY.COM
Tel: 949-273-8820
26501 RANCHO PKWY SOUTH, SUITE 202
LAKE FOREST, CALIFORNIA 92630

## PATIENT INFORMATION

Date: _____ (Double click in Data Tab for Automated Fill in) ☐NEW PATIENT ☐UPDATE

Patient: _____ _____ _____ _____ _____
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____ _____ _____
CITY ST ZIP CODE

E-Mail: _____

HOME: _____
CELL: _____
OTHER: _____
PAGER: _____
FAX: _____

Referral? ☐Yes ☐ No Referred by: _____

## PATIENT EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ _____ Tel: _____
NAME RELATIONSHIP

## PATIENT EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____ _____ _____
CITY ST ZIP CODE

E-Mail: _____

WORK: _____
DIRECT: _____
OTHER: _____
PAGER: _____
FAX: _____

## PATIENT INSURANCE INFORMATION

Subscriber: _____ _____ _____ _____ _____
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

**PRIMARY INSURANCE CARRIER:** _____

Group/Policy No.: _____ ID No.: _____

Plan Type: ☐HMO ☐PPO ☐POS ☐OTHER TEL: _____

Address: _____ TOLL-FREE: _____

FAX: _____

_____ _____ _____
CITY ST ZIP CODE

**SECONDARY INSURANCE CARRIER:** _____

Group/Policy No.: _____ ID No.: _____

Plan Type: ☐HMO ☐PPO ☐POS ☐OTHER TEL: _____

Address: _____ TOLL-FREE: _____

FAX: _____

_____ _____ _____
CITY ST ZIP CODE

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***NAME:*** ***DATE:***

**PATIENT PREVIOUS DENTIST INFORMATION IF AVAILABLE**

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

_____

CITY ST ZIP CODE

Reason for changing: _____

**PATIENT DENTAL HISTORY**

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: _____
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you want to become a regular continuing care patient in our practice?
☐Y☐N Do you want your mouth properly restored and pain free?
☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns/comments?

_____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (Thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

☐Y☐N Any unusual speech habits? If yes, explain: _____
☐Y☐N Any lost teeth? If yes, list: _____
☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

**PATIENT PRIMARY PHYSICIAN INFORMATION**

Physician: Telephone:

Clinic/Facility: _____

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***NAME:*** ***DATE:***

## PATIENT MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 4 years?
☐Y☐N Any serious illnesses or surgeries?
☐Y☐N Use tobacco in any form? If Yes, Type:
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

| | | | |
|---|---|---|---|
| Y☐ N☐ ACID REFLUX | Y☐ N☐ BULIMIA | Y☐ N☐ HEARING PROBLEMS | Y☐ N☐ PSYCHIATRIC TREATMENT |
| Y☐ N☐ ADHD | Y☐ N☐ CANCER/MALIGNANCY | Y☐ N☐ HEART ATTACK | Y☐ N☐ RADIATION/CHEMO |
| Y☐ N☐ AIDS/HIV | Y☐ N☐ CEREBRAL PALSY | Y☐ N☐ HEART DISEASE | Y☐ N☐ RESPIRATORY DISEASE |
| Y☐ N☐ ANEMIA | Y☐ N☐ CHEMICAL DEPENDENCY | Y☐ N☐ HEART MURMUR | Y☐ N☐ RHEUMATIC FEVER |
| Y☐ N☐ ANOREXIA | Y☐ N☐ CHICKEN POX | Y☐ N☐ HEPATITIS | Y☐ N☐ SINUS PROBLEMS |
| Y☐ N☐ ANXIETY | Y☐ N☐ CONVULSIONS | Y☐ N☐ HIGH BLOOD PRESSURE | Y☐ N☐ STROKE |
| Y☐ N☐ ARTIFICIAL HEART VALVE | Y☐ N☐ DEPRESSION | Y☐ N☐ KIDNEY DISEASE | Y☐ N☐ THYROID CONDITION |
| Y☐ N☐ ARTIFICIAL JOINTS | Y☐ N☐ DIABETES | Y☐ N☐ LIVER PROBLEMS | Y☐ N☐ TUBERCULOSIS |
| Y☐ N☐ ARTHRITIS | Y☐ N☐ DIZZINESS/FAINTING | Y☐ N☐ MITRAL VALVE PROLAPSE | Y☐ N☐ ULCERS |
| Y☐ N☐ ASTHMA | Y☐ N☐ EPILEPSY/SEIZURES | Y☐ N☐ MONONUCLEOSIS | Y☐ N☐ VENEREAL DISEASE |
| Y☐ N☐ AUTISM/ASPERGER'S | Y☐ N☐ FREQUENT EAR INFECTIONS | Y☐ N☐ PACEMAKER | |
| Y☐ N☐ BLEEDING DISORDER | Y☐ N☐ FREQUENT HEADACHES | Y☐ N☐ OTHER – PLEASE LIST: | |

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

| | | | | |
|---|---|---|---|---|
| Y☐ N☐ ASPIRIN | Y☐ N☐ CODEINE | Y☐ N☐ LACTOSE INTOLERANCE | Y☐ N☐ SLEEPING PILLS | ☐NONE |
| Y☐ N☐ ANESTHETIC – LOCAL | Y☐ N☐ DAIRY | Y☐ N☐ METAL SENSITIVITY | Y☐ N☐ SULFA DRUGS | |
| Y☐ N☐ BARBITURATES | Y☐ N☐ LATEX | Y☐ N☐ NITROUS OXIDE SEDATION | Y☐ N☐ PENICILLIN/OTHER ANTIBIOTICS | |
| Y☐ N☐ OTHER – PLEASE LIST: | | | | |

## MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

| | | | |
|---|---|---|---|
| Y☐ N☐ ANTIBIOTICS/SULFA DRUGS | Y☐ N☐ ANTIHISTAMINES/ALLERGY | Y☐ N☐ DAILY ASPIRIN | Y☐ N☐ BLOOD PRESSURE MEDICATIONS |
| Y☐ N☐ BLOOD THINNERS | Y☐ N☐ CANCER/CHEMO MEDICATIONS | Y☐ N☐ CORTISONE/STEROIDS | Y☐ N☐ HEART MEDICATION/DIGITALIS |
| Y☐ N☐ INSULIN | Y☐ N☐ NITROGLYCERIN | Y☐ N☐ ORAL CONTRACEPTIVES | Y☐ N☐ OSTEOPOROSIS MEDICATIONS |
| Y☐ N☐ OTHER DIABETIC MEDICATIONS | Y☐ N☐ RECREATIONAL DRUGS | Y☐ N☐ THYROID MEDICATIONS | Y☐ N☐ TRANQUILIZERS |
| Y☐ N☐ OTHER (PLEASE LIST BELOW) | | | |

| DRUG NAME | DOSAGE | REASON PRESCRIBED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Dr. Signature / Initial: Date:

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# Financial Agreement

*We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial agreement.*

## Dear Patient

Thank you for choosing ***Baker Ranch Dental Spa & Implant Center*** as your dental provider. The following descriptions are our financial policy, which will help you with your concerns regarding our billing and payment procedures.

- All payments are due by the time of service.
- ***All copays/deductibles will be collected at the time of Service.***
- Our office will claim your insurance on behalf of you. If your carrier is not contracted with our practice, we will courtesy bill them with the understanding that, whatever the insurance doesn't pay, it will be your responsibility to pay between 30 days of your first billing statement date. (***Any bill balanced are due within 30 days of statement date***)
- You will be responsible for knowledge about your insurance benefits. Please be advised by knowing coverage in your plan, participated dentist which you can chose/chosen, deductible/copayments of your plan and etc.
- You need to have your insurance card and photo ID handy all the time for photocopy or other concerns.
- Any changes of insurance, address, phone number or emergency contacts should be reported to front desk immediately.

## Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Remember that the insurance authorization for service do not guarantee payments.** – If your insurance does not pay in full within 60 days, we will ask that you contact them. All remaining/changes will be transferring to you.
- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover, AMX)
  - Various financing options with CareCredit® and CitiHealth®

- **Balances left over 60 days will incur at the rate of 1.5% monthly charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

- **There will be $25.00 fee for all returned check items.** You shall be financially responsible for the costs of collection and/or legal fees.
- Collection costs are calculated by adding to the principle the greater of $25, or an amount 35% in excess of the balance owed.

### Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.

- **Short canceled or missed appointments** will be charged one dollar per minute of time allotted for your appointment.

**By signing below I acknowledge I have read and understand the guidelines above.**

Patient /Guardian name:
Signature: ……. Date:
/ Initial

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## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2016

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Patient name:**

**Signature:** / Initial **Date:**

**RELATIONSHIP TO PATIENT**: ☐ADULT PATIENT ☐PARENT ☐GUARDIAN ☐OTHER

**Please list any dependent children under the age of 18 also covered by this acknowledgement:**

☐ I give permission for the following communications to be used by Dr. Ramin Khoshsar DDM, DDS **(please check all that apply)** :

☐ Cell phone: ☐Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

☐ I am granting permission for Dr. Ramin Khoshsar DDM, DDS to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for Dr. Ramin Khoshsar DDM, DDS to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back
☐ Other (Please explain)

**I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:**

**For Office Use Only:**

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other – please list:

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## PATIENT CONSENT- PAYMENT AUTHORIZATION – SIGNATURE ON FILE

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status of if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Dr. Ramin Khoshsar of the dental benefits otherwise payable to me.

I hereby authorize Dr. Ramin Khoshsar to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

**By signing below, I acknowledge that I have read and understand the statements mentioned above.**

Patient /Guardian name**:**

Signature: Date:

/ Initial

Submit Reset Form Print Forms