MID VALLEY ENDODONTICS

Afshin Mazdey, DDS

(Afshin Mazdeyasnan, DDS)

Diplomate, American Board of Endodontics

PRACTICE LIMITED TO ENDODONTICS AND MICROSURGERY

Member: American Association of Endodontics • American Dental Association • California Dental Association • San Fernando Valley Dental Society

Patient Information / Confidential

Name _____ ❑ Married ❑ Single ❑ Male ❑ Female
Last First M

Address _____
Street Apt.# City State Zip

Bithdate ____ / ____ / ____ Telephone _____
Month Day Year Home Work Cell

SS# _____ DL# _____ Email _____

Name of Dentist _____ City _____

Referred by _____

PERSON TO CONTACT IN CASE OF EMERGENCY – Outside of Immediate Family / Household

Name _____ Telephone# _____

Insurance Information

Insured's Name _____ Insured's SS# _____ Insured's DOB _____

Insurance Company _____ Group # _____

Insurance Co. Address _____

Employer _____ Occupation _____ No. Years Employed _____

Empoyer's Address _____

Do you have dual coverage? ❑ Yes ❑ No If yes: Please complete the following secondary insurance information.

Insured's Name _____ Insured's SS# _____ Insured's DOB _____

Insurance Company _____ Group# _____

Insurance Co. Address _____ Ph# _____

Insured's Employer _____ Ph# _____

Dental Information

Reason for today's visit _____

Check box if you have or have had any of the following:

❑ Grinding Teeth ❑ Bleeding gums ❑ Sensitivity to cold

❑ Sensitivity to hot ❑ Loose Teeth ❑ Sensitivity when biting

❑ Sores or growth in your mouth ❑ Sensitivity to sweets

Medical Information

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations? ❑ Yes ❑ No

If yes, describe _____

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Medications

List medications you are currently taking:

_____

_____

Allergies

❑ Aspirin
❑ Codeine
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other _____
❑ **NONE**

Medical Information

I have or have had the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Disease or Attack	❑	❑	Emphysema	❑	❑	Blood Transfusion
❑	❑	Heart Surgery	❑	❑	Chronic Cough	❑	❑	Hepatitis A (infectious)
❑	❑	Congenital Heart Disease	❑	❑	Allergies or Hives	❑	❑	Hepatitis B (serum)
❑	❑	Angina Pectoris	❑	❑	Sinus Trouble	❑	❑	Venereal Disease
❑	❑	Mitral Valve Prolapse	❑	❑	Cancer	❑	❑	HIV Positive /Aids
❑	❑	Artificial Heart Valve			Describe:_____	❑	❑	Psychiatric Care
❑	❑	Heart Murmur	❑	❑	Radiation Therapy	❑	❑	Nervousness
❑	❑	Pacemaker	❑	❑	Chemotherapy	❑	❑	Developmentally Disabled
❑	❑	High Blood Pressure	❑	❑	Tumors	❑	❑	Liver Disease
❑	❑	Stroke	❑	❑	Kidney Disease	❑	❑	Thyroid Problems
❑	❑	Rheumatic Fever	❑	❑	Diabetes	❑	❑	Glaucoma
❑	❑	Cirulatory Problems	❑	❑	Epilepsy	❑	❑	Ulcer
❑	❑	Artificial Joints	❑	❑	Fainting	❑	❑	Skin Rash
❑	❑	Arthritis / Rheumatism	❑	❑	Blood Disease	❑	❑	Tobacco Habit
❑	❑	HRespiratory Disease	❑	❑	Anemia	❑	❑	Chemical Dependency
❑	❑	Tuberculosis	❑	❑	Hemophilia	❑	❑	Swelling of Feet / Ankles
❑	❑	Shortness of Breath	❑	❑	Prolonged Bleeding	❑	❑	Bisphosphonate
❑	❑	Asthma	❑	❑	Bruise Easily			

CONSENT:

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.

- I understand that it is my responsibility to advise your office of any changes in the information obtained in this form.
- The undersigned hereby authorizes Dr. Mazdeyasnan to order x-rays, photographs, a CBCT scan or any other diagnostic aid deemed appropriate to make a thorough diagnosis of my needs. X-rays and clinical records may be used for teaching purposes.
- I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.
- I understand that responsibility of payment for services provided in this office for myself or my dependants is my own; due and payable at the time services are rendered.
- As a courtesy, Dr. Mazdeyasnan's office staff will complete and file insurance forms. Ultimately, if my insurance plan does not pay or only pays a partial amount, I understand that I am responsible for any remaining balance. Fees quoted by this office are only an estimate and it is not a guarantee of payment by my insurance company.
- I hereby authorize Dr. Mazdeyasnan's office staff to release my information, which may include my social security number to file my insurance claims. I further authorize payments to be sent directly to the dentist.
- I understand that in the event that payment is not received by the agreed upon date a finance charge may be added to my account. Patient is responsible for any additional expenses incurred in processing collections of delinquent accounts, including a 50% collection fee. Dr. Mazdeyasnan may choose to prosecute through small claims court where an additional $750 will be added to the balance.
- Please acknowledge that any appointment scheduled is reserved exclusively for you and we that require 48 hours notice for cancellations. There is a charge for missed appointments without proper notification.

Patient Name: _____ Signature: _____ Date: _____

Parent or Responsible Party: _____ Relationship to patient: _____

FOR OFFICE USE: BP: _____ Pulse: _____ Reviewed by Dr. _____ Date: _____

Medical Updates

I have read my MEDICAL HISTORY dated, and confirm that it adequately states past and present conditions.

Date	Exceptions		Patient's Signature	B.P.	Reviewed By
_____	_____	None ❑	_____	_____	_____
_____	_____	None ❑	_____	_____	_____
_____	_____	None ❑	_____	_____	_____