MID VALLEY ENDODONTICS

Afshin Mazdey, DDS and Associates

(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 CELL HOME WORK

SS#: ______________ DL# ______________ Email ______________

Name of Current Dentist ______________ City ______________

Referred by ______________________________

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

Name: ______________ Relation: ______________ Phone # ______________

Insurance Information

Insured's Name ______________ Insured's SS# ______________ Insured's DOB ______________

Insurance Company ______________ Group # ______________

Ins 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
❑ Ibuprofen
❑ Codeine or other Narcotics
❑ Valium or other Sedatives
❑ Local Anesthetic
❑ Penicillin or other Antibiotics
❑ Latex
❑ Sulfa
❑ Other ______________
❑ **NONE**

Medical Information

I have or have had the following:

Yes	No	
❑	❑	Heart Disease or Attack
❑	❑	Heart Surgery
❑	❑	Congenital Heart Disease
❑	❑	Angina Pectoris
❑	❑	Mitral Valve Prolapse
❑	❑	Artificial Heart Valve
❑	❑	Heart Murmur
❑	❑	Pacemaker
❑	❑	High Blood Pressure
❑	❑	Stroke
❑	❑	Rheumatic Fever
❑	❑	Cirulatory Problems
❑	❑	Artificial Joints
❑	❑	Arthritis/Rheumatism
❑	❑	Respiratory Disease
❑	❑	Tuberculosis
❑	❑	Shortness of Breath
❑	❑	Asthma

Yes	No	
❑	❑	Emphysema
❑	❑	Chronic Cough
❑	❑	Allergies or Hives
❑	❑	Sinus Trouble
❑	❑	Cancer
		Describe: ______________
❑	❑	Radiation Therapy
❑	❑	Chemotherapy
❑	❑	Tumors
❑	❑	Kidney Disease
❑	❑	Diabetes
❑	❑	Epilepsy
❑	❑	Fainting
❑	❑	Blood Disease
❑	❑	Anemia
❑	❑	Hemophilia
❑	❑	Prolonged Bleeding
❑	❑	Bruise Easily

Yes	No	
❑	❑	Blood Transfusion
❑	❑	Hepatitis A (infectious)
❑	❑	Hepatitis B (serum)
❑	❑	Venereal Disease
❑	❑	HIV Positive /Aids
❑	❑	Psychiatric Care
❑	❑	Nervousness
❑	❑	Developmentally Disabled
❑	❑	Liver Disease
❑	❑	Thyroid Problems
❑	❑	Glaucoma
❑	❑	Ulcer
❑	❑	Skin Rash
❑	❑	Tobacco Habit
❑	❑	Chemical Dependency
❑	❑	Swelling of Feet / Ankles
❑	❑	Bisphosphonate
❑		**OTHER:** ______________

Office Policies and 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.
- 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 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, we require 48 hours notice for cancellations. There is a charge of $125 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 reviewed my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

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

Dr. Mazdeyasnan's Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions or would like further information about this Notice, you can contact us at: (818) 885-3636.

We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information. We are required by law to: Maintain the privacy of your protected health information; Give you this Notice of our legal duties and privacy practices with respect to that information; and abide by the terms of our Notice that is currently in effect. This Notice was last revised on October 1st, 2013.

The following examples describe different ways we may use or disclose your health information. We are permitted by law to use and disclose your health information for the following: Treatment: We may use your health information to provide you with dental treatment or services. We may disclose health information about you to other dental specialists, physicians, or health care professionals involved in your care. Payment: We may use and disclose your health information to obtain payment from insurers for the care that we provide to you. We may use and disclose health information about you in connection with health care operations necessary to run our practice. For example, staff will enter your information into our computer. We may disclose your protected health information to our business associates, such as a billing service. Business associates are obligated, under contract with us, to protect the privacy of your information.

We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email. If you are not home we may leave this information on your answering machine. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present.

We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

You have the following rights with respect to certain health information that we have about you. To exercise any of these rights, you must submit a written request to our Privacy Official listed on this notice. You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information, if it is readily producible. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

You have the right to a paper copy of this Notice. To obtain a paper copy, ask the office staff. If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint by contacting Dr. Mazdeyasnan at phone number listed above.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. 200 Independence Ave SW Room 509F Washington, DC 20201. We will not retaliate against you in any way if you choose to file a complaint.

Acknowledgement:

I have read a copy of Dr. Mazdeyasnan's Notice of Privacy Practices. I ______________________________
Printed Name

give consent to the dental practice of Afshin Mazdey, DDS, Inc to use my cell phone number to call or text regarding appointments, treatment, insurance benefits or my account. I understand that I can withdraw my consent at any time.

______________________________ ______________________

Signature **Date**

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AFSHIN MAZDEY, DDS
(AFSHIN MAZDEYASNAN, DDS)
DIPLOMATE, AMERICAN BOARD OF ENDODONTICS
PRACTICE LIMITED TO ENDODONTICS AND MICROSURGERY

Patient Preferred Pharmacy Form

In order to better serve you, your prescriptions will now be electronically processed directly to your pharmacy. Please provide us with your pharmacy information in the space provided below. If you are unable to provide your preferred pharmacy information to us today, you may call us back with the information or fax this completed form to the number provided below. Please note that the information is required for any medication prescribed to you by our Endodontists.

If at any time there is a change in your pharmacy information, please provide the updated information to our Front Desk staff.

Phone: (818) 885-3636
Fax: (818) 885-1236

Patient Name: ______________________________________
Pharmacy Name: ______________________________________
Pharmacy Address: ______________________________________
Pharmacy Phone Number: ______________________________________
Pharmacy Fax Number: ______________________________________

If covered under a Kaiser Permanente Plan, please add your Medical Record #: _____________

NORTHRIDGE MEDICAL TOWER - 18250 ROSCOE BLVD. SUITE 345 NORTHRIDGE, CA 91325
818-885-ENDO (3636) - INFO@MIDVALLEYENDO.COM