PINE TREE
DENTAL CARE

Dental Office of Dr. Irina Babayan

Welcome! We are so pleased that you have selected us to partner in your dental healthcare. Each one of our staff members is here to provide you and your family the very best dental experience possible. Please don't hesitate to let us know how we can help you.

PATIENT INFORMATION

Name						Preferred Name					
Address				City				State		Zip	
Phone #	Home ( )			Work ( )				Cell ( )			
Employer						Occupation					
Date of Birth							SS#				
Status: Please Check One		Minor		Single		Married		Widowed		Divorced	
If Student, School Name					City/ST					FT	PT
Emergency Contact						Relationship				PH#( )	
How did you hear about us?						Do you have any special requests we can help with?					

RESPONSIBLE PARTY

Relationship to Patient		Self		Spouse		Parent		Partner	
Name				Address					
City	State		Zip				PH#( )		
Employer			Work Phone ( )				SS#		

INSURANCE INFORMATION

Name of Insured			Date of Birth		SS#
Employer			Address of Employer		
City	State	Zip		Employer Phone ( )	
Insurance Co Name					
Group-#			ID#		
Insurance Co Address					
City	State	Zip		Insurance Co. Ph# ( )	

DO YOU HAVE ANY ADDITIONAL INSURANCE?

	Yes		No	IF YES, PLEASE COMPLETE SECTION BELOW	
Name of Insured				Date of Birth	SS#
Employer			Address of Employer		
City		State	Zip	Employer PH# ( )	
Insurance Co Name					
Group#				ID#	
Insurance Co Address					
City		State	Zip	Insurance Co Ph# ( )	

ACKNOWLEDGEMENT

___I have reviewed the following treatment plan, and I authorize any information relative to this claim. I hereby authorize payment of my group insurance benefits to Dr. Irina Babayan for treatment rendered, on my behalf.

Signature (Parent or Guardian if Minor)	Date

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MEDICAL HISTORY

Patient Name:_____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS, CURRENTLY, OR IN THE PAST?

Y	N	Heart Disease	Y	N	Liver Disease
Y	N	Heart Murmur/Mitral valve prolapse	Y	N	Jaundice
Y	N	Stroke	Y	N	Hepatitis- Type
Y	N	Congenital Heart Defect/Lesions	Y	N	History of Drug Addiction
Y	N	Rheumatic Fever	Y	N	Excessive Urination/Thirst
Y	N	Abnormal Blood Pressure	Y	N	Infectious Mononucleosis
Y	N	Anemia	Y	N	Venereal Disease
Y	N	Bleeding Disorder	Y	N	Herpes
Y	N	Tuberculosis	Y	N	Kidney Disease
Y	N	Lung Disease	Y	N	Tumor or Malignancy
Y	N	Asthma	Y	N	Cancer/Chemotherapy
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	AIDS	Y	N	Hearing Loss
Y	N	Immune Suppressed Disorder	Y	N	Fainting Spells
Y	N	Glaucoma	Y	N	Emotional Disorders
Y	N	Hay Fever/Seasonal Allergies	Y	N	Implants/Artificial Joints
Y	N	Sinus Trouble			Date :
Y	N	Epilepsy/Seizures			Location of Implant:
Y	N	History or Smoking/Tobacco use- If Yes, How much per day?			
Y	N	Have you consumed alcohol in the last 24hrs	Y	N	Have you taken Phen-Phen or Redux?
Y	N	Are you required to take Antibiotic pre-medication prior to dental visits?			
Women Only					
Y	N	Are you taking Birth Control Medication?	Y	N	Are you currently nursing?
Y	N	Are you or could you be Pregnant?	If Pregnant, due date (if known):		

Primary Care Physician:		
Name	Address	PH#( )

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

	N	Aspirin
Y	N	Ibuprofen
Y	N	Sulfa Drugs/Sulfites/Sulfides
Y	N	Penicillin
Y	N	Antibiotics other than Penicillin
Y	N	Codeine
Y	N	Latex ,Metals, Plastics
Y	N	Local Anesthetics
Y	N	Other Medications

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING BELOW

Medication	Condition	Dosage

YOUR DENTAL HISTORY/CONCERNS

Y	N	Do you grind or clench your teeth	Y	N	Have you had a jaw or facial injury
Y	N	Do your gums bleed while brushing or flossing	Y	N	Have you had Orthodontic treatment
Y	N	Gums tender or swollen	Y	N	Had a tooth extracted due to pain/abscess
Y	N	Problems eating due to tooth pain	Y	N	Broken a tooth

Date of last Dental Visit	Previous Dentist:	Reason for leaving:

YOUR DENTAL GOALS

Y	N	Do you like your smile?	Y	N	Are you concerned about bad breath?
Y	N	Would you like your teeth straighter?	Y	N	Would you like to be less anxious about dental visits?
Y	N	Would you like your teeth whiter?	Y	N	Would you like help navigating your dental benefits?
Y	N	Would you like help protecting your teeth from grinding?	Y	N	Do you have a dental goal not listed?

Clinical Notes:

Patient Signature		Date

Reviewed by: Date	Date	Date	Date	Date	Date

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FINANCIAL POLICY

We are committed to providing our patients with access to the best dental care possible.

Our primary goal is to provide a comprehensive treatment plan based on an individual's dental needs. We are here to help you achieve a healthy, beautiful smile!

Our secondary goal is to help you achieve that treatment plan by:

- Maximizing your Insurance benefit, where applicable.
- Providing payment arrangement options for co-pays or patients without Insurance.

Full Payment Option For most procedures, payments/co-pays are expected when treatment is rendered. We accept cash, checks, debit and credit cards. Discounts are available for full cash/check payment on day of service.

Two Payment Option Major procedures, such as crowns, bridges, dentures, and implant restorations can be paid in two payments. We ask that you pay half of your payment /co-pay at the first appointment, and the other half at the second appointment.

Term Loan By arrangement with CareCredit we are able to offer our patients (upon approval) an interest- free term loan up to twelve (12) months with no down down payment, or annual fee. Please ask for an application.

Broken Appointments Policy A specific treatment time has been reserved for you. If you must change an appointment, we require at least 24-hour notice. For appointments cancelled less 24 hours prior, or no shows, a $35 fee will apply. We confirm all our appointments by phone in advance.

Please initial to indicate receipt of this policy____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Note: you may refuse to sign this acknowledgement

I ,_____, have received a copy of Pine Tree Dental Care's Notice of Privacy Practices.

Signature_____ Date_____

APPOINTMENT REMINDERS We may use or disclose your health information to provide you with appointment reminders or information about treatment such as voicemail messages, postcards, or letters.

____YES ____NO

MINOR CHILD If you are the parent of a minor child, are there other individuals who may make the decisions for your minor child?

____YES ____NO

If yes, please list names: _____

Most families in our computer system are together in one account. We will continue with our existing set up unless you request your own individual account. All children will be given their own account when they reach the age of 18. All new adult patients will be given their own account.

____OK to leave together ____Please provide separate accounts

For all patients over 18 years of age, may we communicate with the family member who holds the dental insurance for billing purposes?

____YES ____NO

For Office Use Only

____*Individual refused to sign*

____*Communication barriers prohibited obtaining the acknowledgement*

____*An emergency situation prevented us from obtaining acknowledgement*

____*Other:* _____