asinmaz
Cosmetic · Implant · General Dentistry
Mihran Asinmaz, DMD

PATIENT INFORMATION		
MR/MRS/MISS:	DATE:	DATE OF BIRTH:
HOME ADDRESS:		HOME TEL.:
CITY. STATE. ZIP:		SOC.SEC.NO:
OCCUPATION:		BUS TEL:
EMPLOYER:		EMAIL:
BUS. ADDRESS:		CELL:
CITY.STATE.ZIP:		Preferred Time to call:
PERSON RESPONISBLE FOR ACCOUNT:		Pharmacy: Number:
DENTAL INSURANCE COMPANY AND POLICY #:		
REFERRED BY:		
REMARKS:(Please indicate other information that should be known about your health or previous dental visits)		
EMERGENCY CONTACT:	RELATION:	PH:

DENTAL HISTORY	
HOW LONG HAS IT BEEN SINCE YOUR LAST DENTAL VISIT:	
WHAT WAS DONE AT THAT TIME:	
PURPOSE OF THIS APPOINTMENT:	
MEDICAL HISTORY	
1. Date of your last physical exam:	2. Are you under a physician's care now?
IF so, please give reason for treatment:	
3. Are you taking any medications at this time?:	Please list medications:
Medications Cont'd:	

4. Please circle any Illness or condition you have had in the past:

ALLERGIES	TUBERCULOSIS	ANEMIA	KIDNEY OR LIVER	ARTHRITIS
RHEUMATIC FEVER	DIABETES	ASTHMA	NERVOUS PROBLEMS	MALIGNANCY
PROSTHETIC REPLACEMENT	EPILEPSY	EMPHYSEMA	AIDS	RADIATION TREATMENT
INFECTIOUS HEPATITIS	SKIN AILMENTS	GLAUCOMA	SINUS PROBLEMS	ULCER THYROID

Heart Trouble (please check all that apply): Valve problem__ pacemaker__ open heart surgery___

murmur___ high blood___ low blood pressure___

5. Physician's Name:_____

Address:_____ Phone:_____

6. Have you ever had trouble with prolonged bleeding after a cut or surgery?_____

7. PLEASE CIRCLE ALLERGIES THAT APPLY: ASPIRIN BARBITURATES (SLEEPING PILLS) CODEINE IODINE

LATEX LOCAL ANESTHETIC PENICILLIN SULFA OTHER:_____

8. FEMALE: Are you pregnant?_____ How many months:_____

Signature:_____ Date:___/____/____

470 Columbia Drive • Suite D-101, West Palm Beach, Florida 33409
Tel: (561) 640-9200
info@palmbeachdentalexcellence.com | www.palmbeachdentalexcellence.com

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DENTAL INSURANCE POLICY:

As a courtesy to you , our office will submit dental claims to your insurance company and do everything possible for you to obtain your maximum benefits through prompt and efficient claims processing. Please keep in mind that our financial agreement is with you as the patient, and NOT with your insurance company. We cannot guarantee insurance payments as each policy is different and often change.

It is ultimately your responsibility for payment and the benefit quoted by your insurance company is not a guarantee. If your dental insurance denies a claim, we will research the claim and re-file. If the insurance company denies the claim a second time or pays less than the original estimate, you will be responsible for the balance.

In the event the insurance company pays more than expected, we will either refund the amount to you or leave the credit balance on your account to be applied to any future treatment. This will be your preference.

It is your responsibility to provide us with updated insurance information. Insurance benefits are estimates only. I understand that I am responsible for any co-payments and deductibles, along with any procedures that my insurance company does not cover. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to my family or to me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the treating dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents. I am also responsible for any balance due because of insurance claims not paid within 60 days of services.

_____
Name of Patient (Parent if Minor) or Responsible Party (Please Print)

X_____ _____
Signature of Patient (Parent or Minor) or Responsible Party Date

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

*** You May Refuse to Sign This Acknowledgement***

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement if receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**

_____
_____
_____

Smile Evaluation Form

Are you happy with the appearance of your teeth/gums/smile?.....Yes No

Would you like to discuss enhancing the appearance of your smile?.....Yes No

What don't you like about your smile?

_____

_____

Would you like to discuss how to make your teeth white?.....Yes No