The offices of
Bahman Guiv D.D.S, P.A.
Maryam Nejat D.M.D

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have questions, please don't hesitate to ask us.

Patient Information

Patient Name: _____
First Last
Address: _____

City: _____ State: _____ Zip: _____

Sex: Male ☐ Female ☐ Age: _____ DOB: _____

IF PATIENT IS A MINOR:
Parent/Guardian: _____
DOB: _____ SSN: _____

Home Phone: _____
Cell: _____
Work: _____
E-Mail: _____

Please Mark One:

☐ Single ☐ Married ☐ Widowed ☐ Minor
☐ Seperated ☐ Divorced ☐ Partnered

In Case of an Emergency, Contact:

_____
Relationship: _____
Phone: _____

Insurance Information

Subscriber Name: _____
First Last
Relationship to patient: _____
Insurance Company: _____
Phone #: _____ Employer _____
ID/SSN: _____ Group #: _____

Is the patient covered by additional dental insurance: ☐ Yes ☐ No

Secondary Subscriber Name: _____
Relationship to Patient: _____
Ins. Company Name: _____
Phone: _____ Employer: _____
ID/SSN: _____ Group #: _____

ASSIGNMENT AND RELEASE:
I certify that I, _____ and/or my dependant(s) have dental insurance with above named insurance company and assign payment directly to Maryam Nejat D.M.D. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance company. I authorize use of my signature on all insurance submissions.
Dr. Maryam Nejat may use my health care information and may disclose such information to the above named insurance company/ies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

How Do You Feel Today?


Happy ☐


Sad ☐


Anxious ☐


Curious ☐


Indifferent ☐


Exhausted ☐

Medical Doctor's Name: _____ Phone: _____ Location: _____

Dental History

What is the reason for your appointment today: _____
Are there any specific dental problems we should be aware of? _____

Do you think you have any decay or cavities?	Yes	No	How often do you brush? _____
Do you gums bleed easily when brushing or flossing?	Yes	No	How often do you floss? _____
Do you suffer from chronic bad breath or bad taste?	Yes	No	
Do you have any jaw joint cracking or pain?	Yes	No	

When was the last time you had a dental cleaning? _____
When was your last Full set of X-rays taken: _____

How would you describe your dental health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Whom may we thank for referring you to our office: _____

Medical History

None ☐

Please check X if you have or have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Blood Transfusion	☐	☐	Hemophilia	☐	☐	Radiation/Chemo Therapy
☐	☐	Adrenal Problems	☐	☐	Bronchitis	☐	☐	Hepatitis	☐	☐	Rheumatic Fever
☐	☐	Alcoholism	☐	☐	Bypass	☐	☐	High Blood Pressure	☐	☐	Sickle Cell Trait
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Kidney Problems	☐	☐	Sinus Trouble
☐	☐	Angina	☐	☐	Difficulty Healing	☐	☐	Liver Problems	☐	☐	Smoker
☐	☐	Artificial Heart Valves	☐	☐	Emphysema	☐	☐	Low Blood Pressure	☐	☐	Stomach Trouble/Ulcer
	☐	Pre-Med needed	☐	☐	Epilepsy/Seizures	☐	☐	Lung/Breathing Issues	☐	☐	Stroke
☐	☐	Artificial Joints	☐	☐	Heart Problems	☐	☐	Nervous Disorder	☐	☐	Thyroid Problems
	☐	Pre-Med needed	☐	☐	Heart Murmur	☐	☐	Mental Disorder	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Heart Attack	☐	☐	Pacemaker	☐	☐	Venereal Disease

Females Only: Are you pregnant? ☐ Yes ☐ No

Medications

None ☐

Medication:	Taken For:

Allergies

None ☐

☐ Latex	☐ Penicillin	☐ Erythromycin	☐ Sulfa
☐ Codeine	☐ Aspirin	☐ Local Anesthetic	☐ Other _____

HIPAA Consent

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide to sign this consent. If you wish to do so, please ask our front desk administrator for a copy. Our Notice provides a description of our treatment, payment activities and health care operations, and any uses and disclosures we may make of your protected health information and of other important matters of your protected health information. A copy of our Notice will be provided to you at your request. Please read it carefully before you sign this consent. We deserve the right to change our privacy Practices, as described in our Notice of Privacy Practices. If we change it, we will issue you an updated copy at your request, which will describe the changes made therein. These change may apply to any or all of your protected health information that we maintain.

RIGHT TO REVOKE: You have the right to revoke this consent at any time if you do not want us to discuss your information with another dentist of your choice, check insurance benefits and eligibility. You will need to give us written notice of revocation. Please remit your revocation directly to the office address. Please understand revocation of this consent will not affect any action we took before we received your revocation and we may decline to treat you as a patient if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form. I also acknowledge this office's Notice of Privacy Practices form is available. I understand that by signing this Consent form, I am giving my consent for you to disclose the use of my protected health information to carry out treatment, payment activities and health care operations.

I certify the information on this entire form is accurate and complete to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____