Patient Information Today's Date:________________________________

First Name:_____________________________ M.I.___Last Name:____

Date of Birth: ____________ Age____ Sex: M / F Soc. Sec. # ___________________E-mail___________________________________

Driver's Lic. # ___________________________

Street____ Apt.______ City___________________State_____Zip_________

Home Tel.: (____) ______________ Cell.: (____) ______________Have you ever been a patient of our practice? Y / N

Dentist:______________________________Orthodontist:__________________________Medical Dr_____________________________

Nearest relative not living with you:____ Tel.: (____)___________________________

Employer ____ Business Tel.: (____)_________________________

In case of emergency, please contact______________________________Relation:______________Tel.: (____)_____________________

Who will be responsible for your account:

__Self (if self, skip this section) __Spouse __Father __Mother __Other____

Tel.: (____)_________________________ Cell.: (____)__________________________ E-mail________________________________

Street____ Apt.______ City__________________State_____Zip___________

Driver's Lic. # ___________________________ Employer _______________________ Business Tel.:(____)______________________

Insurance information:

Student: __Full time __Part time __Not.. Name of School and address____

Marital Status: __Married __Divorced __Widow __Single __Legally Separated

Employed __Full Time __Part Time __Retired

Primary Dental Insurance Company

Employer ____

Business address____ City_________________State______ Zip__________

Bus. Tel. (____) __________________________ Plan___________________________________

Ins. Company name____ I.D.# _______________________________________

Ins. Company Address____ City__________________State____Zip__________

Tel. (____)_______________________ Group name ____________________________________Group #_________________________

Insured party ____ Relation______________________ Birth Date___________

S.S # ______________________________ Tel. (____) ____________________________

Address____ City_________________ State______ Zip_____________

Secondary Dental Insurance Company

Employer ____

Business address____ City_________________State______ Zip__________

Bus. Tel. (____) __________________________ Plan___________________________________

Ins. Company name____ I.D.# _______________________________________

Ins. Company Address____ City__________________State_____Zip____________

Tel. (____)_______________________ Group name ____________________________________Group #________________________

Insured party ____ Relation______________________ Birth Date_______________

S.S # ______________________________ Tel. (____) ____________________________

Address____ City_________________ State______ Zip________________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be kept confidential.

1. Are you in good health? .... Yes No
2. Has there been any change in your health in the past year? .... Yes No
3. My last physical exam was on ________/_______/_______
4. Are you now under the care of a physician? .... Yes No
   If so, for what condition? ____
5. The name and address of my physician is: ____
   ____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? .... Yes No
7. Have you had an artificial joint replacement (knee, hip, shoulder, etc.)? .... Yes No
8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia) ? .... Yes No
9. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? .... Yes No
   If so, please list:
   ____
   ____
   ____
   ____
   ____
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur .... Yes No
    b. Rheumatic Heart Disease .... Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition .... Yes No
       1. Chest pain upon exertion? .... Yes No
       2. Shortness of breath after mild exercise? .... Yes No
       3. Do your ankles swell? .... Yes No
    d. Allergies .... Yes No
    e. Sinus trouble .... Yes No
    f. Asthma or hay fever .... Yes No
    g. Fainting spells or seizures .... Yes No
    h. Diabetes .... Yes No
    i. Hepatitis, jaundice or liver disease .... Yes No
    j. Frequent or recurring mouth sores .... Yes No
    k. Thyroid problems .... Yes No
    l. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) .... Yes No
    n. Osteoporosis .... Yes No
    o. Stomach ulcer or hyperacidity .... Yes No
    p. Kidney trouble .... Yes No
    q. Tuberculosis .... Yes No
    r. Persistent cough or cough that produces blood .... Yes No
    s. Persistent swollen neck glands .... Yes No
    t. Low blood pressure .... Yes No
    u. Epilepsy or neurological disorder .... Yes No
    v. Cancer .... Yes No
    w. Any disease, drug or transplant operation that has depressed your immune system .... Yes No
11. Have you had abnormal bleeding? .... Yes No
    a. Have you ever required a blood transfusion? .... Yes No
12. Do you have any blood disorder such as anemia? .... Yes No
13. Have you ever had treatment for a tumor or growth? .... Yes No
14. Have you had radiation therapy to the head, neck or jaws? .... Yes No
15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics .... Yes No
    b. Penicillin or antibiotics .... Yes No
    c. Sulfa drugs .... Yes No
    d. Barbiturates or sleeping pills .... Yes No
    e. Aspirin .... Yes No

f. Iodine .... Yes No
g. Codeine or other narcotics .... Yes No
h. Latex or rubber products .... Yes No
i. Other .... Yes No

16. Have you had any serious trouble associated with previous dental treatment? .... Yes No
    If so, explain:____
    ____
17. Do you have any other condition or disease you think the doctor should know about? .... Yes No
    If so, explain:____
18. Do you smoke or chew Tobacco? .... Yes No
    How much? ____________________
19. Is there any past history of alcohol or chemical dependency or emotional disorder
    that may affect the care we provide you? .... Yes No
20. Are you wearing contact lenses? .... Yes No
21. Are you wearing removable dental appliances? .... Yes No
22. Do you wish to talk with the doctor privately about anything? .... Yes No

Women

20. Are you pregnant or trying to become pregnant .... Yes No
21. Do you have problems associated with your menstrual period? .... Yes No
22. Are you nursing? .... Yes No
23. Are you taking birth control pills? .... Yes No

Chief Dental Complaint: ____
____

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Date:____________________Patient's Signature:____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: ____
____
____
____

Significant findings from questionnaire or oral interview: ____
____
____
____

Dental management considerations: ____
____
____
____

Date:____________________ Doctor's Signature:____

Medical History Update:

Date	Comments	Signature

ASSIGNMENT OF BENEFITS FORM

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by:

Garabedian and Kotikian Dental Corporation
242 N. Glendale Ave.
Glendale, CA 91206

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for product received.

Name of the Insured: ____

Signature of Insured or Parent/Guardian: _____________________________

Date: _______________________

Pacific Oral and Maxillofacial Surgery and Dental Implant Center
Insurance and Billing Policy

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different insurance companies with many different polices. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy exclusions, deductibles and required co-insurance before your office visit. We file claims to both medical and dental insurance carriers by nature of our dental/medical specialty. Please be advised that we will process claims on your behalf.

Our courtesy service to you includes:

- Filing your insurance claim in a timely manner of your visit and requesting payments of your benefits. Researching your insurance plan to help you understand your valid insurance benefits. Following the American Dental Association, American Medical Association guidelines for coding procedures and filing to your insurance company.
- We accepts payment via all major credit cards, personal check, cash, and offers payment plans through Care Credit.
- An *estimated* patient payment is collected at the time of service based on the information we obtain by phone verification with your insurance carriers. This payment is again only an **ESTIMATE** derived from what we are told by your insurance carrier. It is not a guarantee of benefits or payment by your insurance carrier. We will bill you for outstanding amounts once the insurance coordination of benefits is complete.

Our expectations of you as the owner of the policy:

- In the event that your specific dental and medical plan denies payment for a covered service that did not meet the criteria for coverage according to your group's provisions, you, the member, are solely responsible for the fees your insurance company refused or failed to pay.
- Payment of all fees not covered by your insurance plan is due at the time the services are rendered.
- This includes payment in full for services when the Doctor does not participate with your insurance plan or you have exceeded your maximum annual benefit.
- Understand that the insurance policy belongs to you and we have no leverage to obtain payment from insurance carrier. If we submit a bill to your insurer for services rendered and we do not receive payment within 90 days the full balance becomes the responsibility of the patient or the guarantor on the account.
- Realize that insurance policies restrict payment for some services, use restricted fees schedules and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the contract between the insurance company and your employer.
- Keep our office informed of any changes in your insurance coverage or employment.
- *A 35% surcharge* will be added to your balance if your account is turned over to a Collection Agency.
- **Remit payment direction to NJCOMS should your medical and/or dental carriers render payment directly to their subscribers. Should you receive a check, it is your responsibility to endorse the check for deposit only to *Garabedian and Kotikian Dental corporation* and forward it along with attached explanation of benefits (EOB) you receive. Please keep a copy for your records. Your account will be sent to a Collection Agency if you receive insurance payments and fail to forward them within 15 business days of release by insurance carrier to you, at which time surcharges will apply.**

Our office will assist you with predetermination of benefits and **estimated** expenses for treatment. We also furnish sufficient documentation to assist you in obtaining the benefits to which you are entitled. Thank you for your cooperation. **Please sign the space below and have your insurance card & driver's license ready for us to copy for our file.**

I hereby authorize Dr. Hamlet Garabedian and Armond Kotikian to release to my insurance company, information acquired in the course of my care. I hereby authorize benefits to be paid directly to this office.

Signature of Patient, Parent or Guardian:________________________________Date:______________

Witness________________________

242 N. Glendale Ave.; Glendale CA 91206
Tel: 818-484-8939 Fax: 818-649-1207
glendaleomfs@gmail.com