CARLSBAD
Dental Associates & Orthodontics
EXCELLENCE IN DENTISTRY

Dear Patient,

It is with great pleasure that we welcome you to our dental practice at Carlsbad Dental Associates. We want you to know that we appreciate the opportunity to take care of you and your family. Our dental team, lead by Dr. Edward Adourian, is very proud of the full line of dental services and products that we offer in our multi-specialty office, all with the sole purpose of providing you with high quality and gentle dental care.

During your first visit, the doctor will examine your teeth, perform an oral cancer exam, take necessary digital x-rays, and make an assessment of your oral condition. Staff members will assist the doctor on completing your dental health evaluation and you will be meeting several members of our dental team. If it is discovered that you need any dental treatment, a treatment plan and estimate will be prepared for you prior to the beginning of any procedure. You will have the opportunity to review the recommended treatment plan and ask questions, which we will be happy to answer in detail.

Please fill out the New Patient Packet which will give our team the information needed to provide you with the best dental care. Also please read and sign forms that provide you with important information to help you make informed decisions about your dental health care.

If you have dental insurance, we will need to have a copy of your insurance card. We also ask you to always notify us of any changes in your dental insurance coverage so we can update your records. If you are unsure about the type of dental insurance you have, our staff will be happy to assist you in obtaining and understanding your benefits.

Thank you again for choosing our office. We are looking forward to taking care of you today and in the future. Enjoy your visit and welcome to our office.

Sincerely,

Dr. Edward Adourian

5814 Van Allen Way, Suite 220
Carlsbad, CA 92008

Ph. 760.918.9000
Fax 760.918.9009

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PATIENT INFORMATION

PLEASE FILL THIS FORM OUT COMPLETELY

Date_____ Patient's Name_____ Spouse_____
Last First Middle

Address_____ Birthdate ____/____/____
Street City State Zip

Home Phone (_____)_____ Cell Phone(_____)_____ Work Phone (_____)_____

Social Security _____ Drivers License # _____ Email _____

Emergency Contact _____Relationship to patient _____ Phone (_____)_____

How did you hear about our office?

❑ Yelp ❑Sign ❑ Insurance ❑Internet ❑Friend ❑Family Member ❑Phone Book ❑Flyer

HOW WOULD YOU LIKE TO BE CONTACTED?

❑ Phone Call ❑Text ❑Email

Responsible Party (Accompanying Parent/Guardian)

Name_____ Phone (_____)_____
Last First Middle

Residence _____
Street City State Zip

Social Security _____ Birthdate ____/____/____ Relationship to patient _____

Employer _____ Phone (_____)_____

INSURANCE INFORMATION

As a courtesy to our patients, we file your dental insurance. Dental insurance is not like medical coverage and rarely covers the same percentage. Your dental insurance is a contract between you or your employer and your insurance company for your benefit. The professional treatment and dental services offered by Carlsbad Dental Associates and your dental insurance are for your best oral health and will not be dictated by insurance coverage.

You are responsible for the deductible and percentage not covered by insurance for the work performed by Carlsbad Dental Associates on the day of service. We have many payment options available at any time to discuss the best option for you.

We file many of our claims electronically; therefore a signature on file is required by all dental insurance companies. We must have a filled out insurance form to file our insurance for you.

We will always do our best to help you maximize you dental benefits, however, ultimate responsibility for payment is yours and financial arrangements must be defined prior to beginning dental treatment.

Insured's Name _____ Insured's Birthday ___/___/___ SSN or ID# _____

Insurance Company _____ Phone # _____ Group# _____

Employer _____

Do you have dual coverage? ____YES____NO If yes, please complete the following secondary information:

Insured's Name _____ Insured's Birthday ___/___/___ SSN or ID# _____

Insurance Company _____ Phone # _____ Group# _____

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HEALTH HISTORY (PAGE 1)

PHYSICIANS NAME: _____ Phone No: _____ City:_____
If no physician, please initial _____

1. Have you ever or are you currently taking Bisphosphonates for osteoporosis, myeloma or other cancers (reclast, fosamax, actonel, bonival, aredia zomets)? ❑Yes ❑No

2. Are you now taking any medications or drugs? ❑Yes ❑No
If yes, please specify: _____

3. Are you sensitive or allergic to any medication or anesthetics? ❑Yes ❑No
If yes, check: ❑ Penicillin ❑Tetracycline ❑Sulfa Drugs ❑Aspirin ❑Codeine ❑Latex ❑ Other: _____

4. Have you ever had Fen-Phen in the past? ❑Yes ❑No

5. Indicate which of the following you have had or have at present. Check 'yes' or 'no' to each item.

Heart Failure	❑ Yes	❑ No	Artificial Joints	❑ Yes	❑ No
Allergy to Latex	❑ Yes	❑ No	Heart Disease or Attack	❑ Yes	❑ No
Hepatitis (Serum)	❑ Yes	❑ No	Developmentally Disabled	❑ Yes	❑ No
Angina Pectoris	❑ Yes	❑ No	Breast Implants	❑ Yes	❑ No
Venereal Disease	❑ Yes	❑ No	Congenital Heart Disease	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	A.I.D.S	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
HIV Positive	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Cold Sores/Fever Blisters	❑ Yes	❑ No
Arteriosclerosis	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
Blood Transfusion	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No	Chronic Cough	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Heart Pacemaker	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No	Sickle Cell Disease	❑ Yes	❑ No
Heart Surgery	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
Bruise Easily	❑ Yes	❑ No	Kidney Trouble	❑ Yes	❑ No
Hay Fever	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No	Allergies or Hives	❑ Yes	❑ No
Yellow Jaundice	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Sinus Trouble	❑ Yes	❑ No	Epilepsy or Seizures	❑ Yes	❑ No
Cortisone Medicine	❑ Yes	❑ No	Radiation Therapy	❑ Yes	❑ No
Fainting or Dizzy Spells	❑ Yes	❑ No	Drug Addiction	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Nervousness	❑ Yes	❑ No
Stroke	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No Type_____
Tumor	❑ Yes	❑ No			

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HEALTH HISTORY (PAGE 2)

6. Do you have or have had any disease, condition, or problem not listed? ❑ Yes ❑ No
If yes, please list: _____

7. Are you pregnant? ❑ Yes ❑ No If yes, what month? _____
Are you nursing? ❑ Yes ❑ No
Are you taking birth control pills? ❑ Yes ❑ No

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.

Patient Signature _____ Date _____

For Office Use Only Reviewed by Dr. _____ Date _____

Dr _____ Pt _____ Date_____ Dr _____ Pt _____ Date_____
Dr _____ Pt _____ Date_____ Dr _____ Pt _____ Date_____
Dr _____ Pt _____ Date_____ Dr _____ Pt _____ Date_____
Dr _____ Pt _____ Date_____ Dr _____ Pt _____ Date_____

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DENTAL INFORMATION

❑ I prefer: to learn every detail of my care OR just an overall explanation
❑ I prefer: long-lasting solutions OR temporary low cost solutions
❑ I prefer: to let my insurance coverage control my care OR to let my dentist determine my dental needs

What is your main concern regarding your teeth?

Have you ever been advised that you have periodontal problems (gum infection)?

Are there things that you would like to change about your smile?

Are you interested in getting your teeth whitened, if it is affordable?

Have you ever had orthodontics in the past?

Do you have a concern regarding silver mercury fillings?

Are you a high fear patient, and would you be interested in sedation?

Is there anything that you would like the doctor to address?

Are you having pain or discomfort at this time? ❑ Yes ❑ No
Explain:_____
Do your gums bleed when you brush? ❑ Yes ❑ No Do you grind or clench your teeth? ❑ Yes ❑ No
Do you have any fear of dental work? ❑ Yes ❑ No
Are your teeth sensitive to heat or cold? ❑ Yes ❑ No Pressure? ❑ Yes ❑ No Sweets? ❑ Yes ❑ No
Do you smoke? ❑ Yes ❑ No If yes, how much per day? _____
Do you drink alcohol? ❑ Yes ❑ No If yes, how much daily? _____
Date of last dental examination? _____ What was done at the time? _____
How would you describe your current dental problem? _____
I am interested in: ❑ teeth whitening ❑ cosmetic evaluation ❑ replacement of mercury ❑ sedation
❑ white fillings ❑ home care ❑ other:
_____

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CONSENT FOR SERVICES FOR PATIENT

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complication.

2. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service. In the event payments are not received by agreed upon dates, you understand that a monthly 1.5% late charge may be added to your account. I also understand that any returned checks or insufficient payments will be assessed a $25 fee and the entire balance will be required to be paid immediately. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, cost, expense and court cost incurred in the collection.

3. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment to the dentist or dental practice to be applied directly to any outstanding balance on my account.

4. I understand if I cancel an appointment with less than 24 hour notice, there may be a failed appointment fee which I agree to pay before any further appointments can be made.

5. By signing this agreement, you give consent to the doctor's or designated staff to use and disclose any oral, written or electronic health records that are individually identifiable as the patient's for the purpose of carrying out treatment, payment and health care operations.

6. I acknowledge that I have reviewed the CDA Notice of Privacy Practices on www.carlsbaddentalassociates.com and can get a copy upon request.

7. I grant my permission to you or your assignee, to telephone me to discuss this statement, my account, appointments or my treatment. or to discuss with the person listed below.

Name:_____ Relationship to Patient:_____

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party):

Patient Name: _____

_____

Signature Patient/Guardian Date

_____

Relationship to Patient

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