DR. SOUDABEH SHARAFI DMD.

SPECIALIZING IN CHILDREN'S DENTISTRY

WWW.DELMARPEDO.COM
Tel: 858-259-1400

12750 CARMEL COUNTRY RD. SUITE 215
SAN DIEGO, CA 92130

PATIENT INFORMATION

Date: _____ ☐NEW PATIENT ☐UPDATE

Patient: _____
LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

_____
PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

_____
SCHOOL/LOCATION

Patient Date of Birth: _____ Patient SSN: _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____
CITY ST ZIP CODE

E-Mail: _____

HOME: _____
CELL: _____
OTHER: _____
PAGER: _____
FAX: _____

Referral? ☐Yes ☐ No Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ Tel: _____
NAME RELATIONSHIP

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____
ADDRESS LINE 1

_____
ADDRESS LINE 2

_____
CITY ST ZIP CODE

E-Mail: _____

WORK: X
DIRECT: _____
OTHER: _____
PAGER: _____
FAX: _____

INSURANCE INFORMATION

Subscriber: _____
LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____
_____
CITY ST ZIP CODE

TEL: _____
TOLL-FREE: _____
FAX: _____

SECONDARY INSURANCE CARRIER: _____

Group/Policy No.: _____ ID No.: _____

Address: _____
_____
CITY ST ZIP CODE

TEL: _____
TOLL-FREE: _____
FAX: _____

Del Mar Pediatric & Adolescents Dental Group

DR. SOUDABEH SHARAFI DMD.

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PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

_____

CITY ST ZIP CODE

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: _____ Treatment Type: _____

Would you like to have a VisiLite oral cancer screening? ☐Y☐N

**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

☐Y☐N Are you currently having dental discomfort? If yes, explain: _____

☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____

☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: _____

☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?

☐Y☐N Have missing teeth been replaced?

☐Y☐N Orthodontic appliances now or in the past?

☐Y☐N Gums bleed when brushing or flossing?

☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N

☐Y☐N Any concerns about the appearance of your teeth?

☐Y☐N Does it hurt to bite or chew?

☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

☐Y☐N Do you want to become a regular continuing care patient in our practice?

☐Y☐N Do you want your mouth properly restored and pain free?

☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns/comments?

_____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

☐Y☐N Any unusual speech habits? If yes, explain: _____

☐Y☐N Any lost teeth? If yes, list: _____

☐Y☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

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MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? _____
☐Y☐N Any serious illnesses/surgeries? _____
☐Y☐N Use tobacco in any form? If Yes, Type: _____
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐PACEMAKER
☐OTHER – PLEASE LIST: _____
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐CODEINE
☐DAIRY
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS
☐NONE
☐OTHER – PLEASE LIST: _____

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

Del Mar Pediatric Dental Group
Soudabeh Sharafi, DMD
Specializing in Children's Dentistry
12750 Carmel Country Rd. Ste 215
San Diego, CA 92130

Financial Agreement and Authorization for Treatment

We charge a 50% finance fee on all accounts with a balance 60 days or older. Payment is due in full at each appointment. For your convenience we offer the following payment methods, please check the one you prefer.....

[ ] Cash **[ ] Insurance Co-pay** **[ ] Credit Card** **[ ] Care Credit/Citi Health**

I authorize for my child. I agree to pay all the fees and charges for such treatment.

Signature: _____ Date: _____

Financial agreement for dental treatment can be made prior to the commencement of treatment. Dental benefit plans may cover only part of your dental treatment. It is understood that you are responsible for the entire balance of your account. The Contract of dental benefits is between the patient and the insurance company.. **You are responsible for all services rendered, regardless if you have dental benefits or not. We bill your insurance company for you as a courtesy. PLEASE REMEMBER THE FINANCIAL OBLIGATION FOR DENTAL TREATMENT IS BETWEEN YOU AND THIS OFFICE AND NOT DEPENDENT UPON INSURANCE.**

Authorization and Release

I authorize my dentist to release any information including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care, third-party payers and/or other heath care practitioners.

I authorize and request my insurance to pay directly to the dentist insurance benefits otherwise payable to Dr. Soudabeh Sharafi.

I authorize and request my dentist to use my signature on file for my signature on all dental insurance forms to expedite computer processing claims.

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 on my behalf of my dependents. If any insurance payment has not been received within 60 days the responsible party is billed immediately.

If I do not pay the entire balance within 60 days of the billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed to the bill for services rendered. I realize a failure to keep this account in good standing may result in you being unable to provide additional dental services except for dental emergencies where there will be prepayment. It is your responsibility to ensure your insurance company pays promptly so you can avoid finances charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

I agree that I am the responsible party: Because a large percent of the population involves divorces situations it is the policy of this office to collect from the parent who brings the child in for dental services. We can give you a letter as a courtesy so the other parent can reimburse you for his/her percentage, but full payment must be paid at the time of the visit. This is standard for most businesses.

I acknowledge that I have read and agree to the above financial policy.

Signature X_____ Date _____

This packet has been reviewed by: (staff member's signature) _____