



Future Dental Care
3752 Florence Street
Redwood City, CA 94063
(650) 780-9429

New Patient Information
Please Print Legibly

Patient Name _____
Patient Date of Birth _____
Patient Social Security Number _____ - _____ - _____
Patient Home Address • City • ZIP Code _____

Patient Home Telephone Number _____
Patient Email Address _____
Patient Is Single • Married • Divorced
Relationship of Patient To Insurance Policy Holder (Self • Spouse • Child)

Policy Holder Name (If Different From Above) _____
Policy Holder Social Security Number (If Different From Above) _____ - _____ - _____
Policy Holder Date of Birth (If Different From Above) _____

Policy Holder Employer _____
Employer Address _____
Employer Telephone Number _____

Insurance Company Name _____
Group Number _____

Office Use Only

Effective Policy Date _____
Maximum Policy Per Calendar Year \$ _____
Personal Deductible \$ _____
Family Deductible \$ _____

Exam _____	6M / 12M / YEAR	Prophy _____	6M / 12M / YEAR
FMX _____	3Y / 5Y	BWX _____	6M / 12M / YEAR / 18M
Preventive% _____	Basic% _____	Major% _____	Crowns% _____
RCT% _____	Perio% _____	Oral Surgery% _____	

Sealants on Molars/Bicuspid up to age _____
Fluoride Treatments up to age _____
Ortho Maximum \$ _____ to age _____
Prior Extractions Covered Yes / No
Crown Replacements Allowed Every _____ Years
Denture Replacement Allowed Every _____ Years



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Medical History
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PATIENT NAME _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? YES NO N/A
Have you ever been hospitalized or had a major operation? YES NO N/A
Have you ever had a serious head or neck injury? YES NO N/A
Have you ever had any serious illness? YES NO N/A
Do you take, or have you taken, Phen-Fen or Redux? YES NO N/A
Do you use tobacco? YES NO N/A
Are you on a special diet? YES NO N/A
Do you use controlled substances? YES NO N/A
Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?
Are you allergic to any of the following?
Aspirin Penicilin Codeine Acrylic Metal Latex Local Anesthetics Other

Do you have, or have you had any of the following?
AIDS/HIV Positive Chest Pains Frequent Headaches Irregular Heartbeat Scarlet Fever
Alzheimer's Disease Cold Sores/Fever Blisters Genital Herpes Kidney Problems Shingles
Anaphylaxis Congenital Heart Disorder Glaucoma Leukemia Sickle Cell Disease
Anemia Convulsions Hay Fever Liver Disease Sinus Trouble
Angina Cortisone Medicine Heart Attack/Failure Low Blood Pressure Spina Bifida
Arthritis/Gout Diabetes Heart Murmur* Lung Disease Stomach/Intestinal Disease
Artificial Heart Valve* Drug Addiction Heart Pace Maker* Mitral Valve Prolapse* Stroke
Artificial Joint* Easily Winded Heart Trouble/Disease Pain In Jaw Joints Swelling of Limbs
Asthma Emphysema Hemophilia Parathyroid Disease Thyroid Disease
Blood Disease Epilepsy or Seizures Hepatitis A Pschiatric Care Tonsilitis
Blood Transfusion Excessive Bleeding Hepatitis B or C Radiation Treatment Tuberculosis
Breathing Problem Excessive Thirst Herpes Recent Weight Loss Tumors or Growths
Bruise Easily Fainting Spells/Dizziness High Blood Pressure Renal Dialysis Ulcers
Cancer Frequent Cough Hives or Rash Rheumatic Fever* Venereal Disease
Chemotherapy Frequent Diarrhea Hypoglycemia Rheumatism Yellow Jaundice

Are you taking any medications, pills, or drugs? YES NO N/A _____

Comments: _____

*Conditions may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or LEGAL GUARDIAN

DATE



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Signature On File
Please Read Carefully And Print Legibly

I authorize the release of any necessary information, including the records of any treatments, to my insurance company or consulting professionals in order to secure payments. The information released to the insurance companies is solely to facilitate billing and reimbursement directly to Dr. Shervin Shariati for treatment that has been completed. I request and authorize my dental insurance company to pay the dentist directly all insurance benefits for services rendered. I authorize the use of the signature on this page on all insurance submissions. A copy of this authorization may be used in place of the original. I also authorize the release of any necessary information to other dental professionals and specialists who may be involved with my treatment.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all dental treatment received at Future Dental Care for myself and all my dependents. I request Future Dental Care to bill my dental insurance company on my behalf. I understand that I am responsible for any amounts not paid by my insurance company for treatment recieved.

Note: Please be advised that Future Dental Care can only estimate the amount that your insurance company will cover for each procedure. We do our best to be accurate, however, insurance company rules and regulations are not entirely divulged to us. Therefore, we are unable to accurately predict the amounts the insurance company will release for each procedure until after they have sent a check. At that time, the difference will be billed to you.

If we have not received any payment from the insurance company within 45 days the treatment was rendered, the full balance will become your responsibility. At that point, payment is expected immediately. Upon payment, we will provide you with any documentation necessary for direct reimbursement from your insurance company.

For all accounts over 45 days past due, there will be a 20.00 late fee and a finance charge of 1.5% (18% APR). All accounts over 120 days will be turned over to a collection agency for processing. There will be a \$30.00 charge for any returned checks.

We accept cash, checks, Visa, MasterCard, and ATM cards as payment. Patients who wish to pre-pay for their entire treatment are eligible for a 10% cash and check, or a 5% credit card or ATM discount.

APPOINTMENT CANCELLATIONS

Please inform us as soon as possible if you must change a scheduled appointment. If we are not notified 24 hours in advance, we may charge your account \$40.00 for each occurrence.

RECORD DUPLICATION

We will be happy to provide you with duplicates of your file, including x-rays and records of treatment. We do charge a fee of \$30.00 for the materials and processing, and we ask for one working day notice in order to have the duplicates ready. We also require your signature on a release form in order to protect your privacy.

I _____ have read and understood the above and agree.

Signature: _____ Date: _____