Michael A. Mazaheri D.D.S
725 W. Elliot Rd. Suite 104
Gilbert, AZ 85233 (480) 633-1481

Notes for Office Use

Thank you for visiting our office. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name ____
LAST FIRST MIDDLE INITIAL NICKNAME

Address ____
STREET

____
CITY STATE ZIP

Employer ____________________ Drivers License # ____________________

Birth date ____________________ Height ____________ Weight ____________

Phone: Home ( ) ____________________ Social Security # ____________________

Work ( ) ____________________ May we contact you at work? ❑ Yes ❑ No

Mobile( ) ____________________ ❑ Male ❑ Female

E-mail ____________________ Marital Status ________________ Occupation ________________

Emergency Contact: Name: ____________________ Phone ( ) ____________________

Insurance

Primary Dental Carrier

Subscriber Name ____________________ Social Security # ____________ DOB ____________

Employer ____________________ Insurance Co. ____________________

Insurance Co. Phone # ____________________ Group # ____________________

Relation to patient ____________________ Subscriber ID# ____________________

Secondary Dental Carrier

Subscriber Name ____________________ Social Security # ____________ DOB ____________

Employer ____________________ Insurance Co. ____________________

Insurance Co. Phone # ____________________ Group # ____________________

Relation to patient ____________________ Subscriber ID# ____________________

Insurance Authorization Statement (Sign & Date)

I hereby authorize the dental office to file my insurance claims, and authorize insurance payments to directly be sent to the Dental Office for my benefit. I understand that I am responsible for all costs and dental treatment. I understand that I am also responsible for the difference of the portion that insurance company may deny, or reduce/downgrade with the associated dental treatment. The information on this page and the medical history is correct to the best of my knowledge. **I understand that cancelled or no show appointments without 24 hour advance notice are subject to a charge of $75.**

Signature______________________________________ **Date** ____________________

If Patient is Under 18

Responsible Party ____________________ Relation to Patient ____________________

Address ____
STREET

____
CITY STATE ZIP

Telephone ( ) ____________________

Other Information

How did you hear about us? ______________________________

What was the reason for today's visit? ______________________________

Is there anything you would like to change about your smile? ______________________________

Why did you leave your last dentist? ______________________________

Medical History and Information

Do you have or have you ever had?

Y	N		Y	N		Y	N	
☐	☐	**Abnormal Bleeding**	☐	☐	**HIV+/AIDS**	☐	☐	**Diabetes (Type: I / Type II)**
☐	☐	**Alcohol Abuse**	☐	☐	**Heart Attack**	☐	☐	**Drug Abuse**
☐	☐	**Anemia**	☐	☐	**Heart Murmur**	☐	☐	**Emphysema**
☐	☐	**Angina Pectoris**	☐	☐	**Heart Surgery**	☐	☐	**Epilepsy**
☐	☐	**Arthritis**	☐	☐	**Blood Disorders**	☐	☐	**Frequent Headaches**
☐	☐	**Artificial Heart Valve**	☐	☐	**Hepatitis A/B/C**	☐	☐	**Glaucoma**
☐	☐	**Asthma**	☐	☐	**High Blood Pressure**	☐	☐	**Sickle Cell Disease**
☐	☐	**Blood Transfusion**	☐	☐	**Artificial Joint Replacement**	☐	☐	**Take Fosamax**
☐	☐	**Cancer**	☐	☐	**Kidney Problems**	☐	☐	**Rheumatic Fever**
☐	☐	**Chemotherapy**	☐	☐	**Low Blood Pressure**	☐	☐	**Seizures**
☐	☐	**Congenital Heart Defects**	☐	☐	**Sexually Transmitted Disease**	☐	☐	**Mitral Valve Prolapse**
☐	☐	**Colitis**	☐	☐	**Pacemaker**	☐	☐	**Shingles**
☐	☐	**Ulcers**	☐	☐	**Psychiatric Problems**	☐	☐	**Stroke**
☐	☐	**Thyroid Problems**	☐	☐	**Radiation Therapy**	☐	☐	**Sinus Problems**
☐	☐	**Latex Allergy**						

Y	N	(if female)
☐	☐	**Are you Pregnant?**
☐	☐	**Are you nursing?**
☐	☐	**Taking Birth Control Pills**

Please list any other condition not listed above (Including any surgeries).

Are you Allergic to any drugs or medications (please list all)?

Are you taking any medications, or drugs (including over the counter). Please provide a complete list.

Treatment Authorization Form

Doctor Signature: _______________ Date: ____________

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated for proper dental care. I hereby authorize the Dental Office to perform diagnostic and therapeutic procedures as may be necessary for treatment. I certify to the above statements regarding my medical history, and the information provided to be correct to the best of my knowledge.

I understand that Payment for all treatment and services rendered are my responsibility. Payments are due at time of service.
I understand that cancelled or no show appointments without 24 hour advance notice are subject to a charge of $75.

______________________________ ______________
PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

______________________________ ______________
PARENT/GUARDIAN SIGNATURE DATE