Hamid Mirsepasi DDS, MSD 1001
Buckingham Road, Suite 112
Richardson, TX 75081
972-231-5744
www.BestRichardsonDentist.com

Patient Information:

Last Name:	First Name:	Middle Initial:
DOB:	Age:	Social Security Number:
Address:		
City:	State:	Zip Code:
Wireless Phone:	Home Phone:	
E-mail:		
Who may me thank for referring you to our office?		
Occupation:		

Primary Insurance:

Insurance Carrier:	Insurance Carrier Phone #:
Subscriber Name:	Subscriber SSN:
Subscriber DOB:	Subscriber ID:
Group #:	Employer:

Emergency Contact Information:

Name of Contact:
Phone Number:
Relationship to Patient:
May we communicate information with this individual concerning your care? ◯ Yes ◉ No

Authorization:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any of my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I am agreeing to responsibility of services not paid in full or part by my dental care payer.

I attest to the accuracy of the information on this page.

Patient or Guardian Signature Date

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Dental History:

Patient Name: Reason for today's visit:

Former Dentist: Date of last Dental visit:

Indicate which of the following you have had or have at present:

- ☐ Bad breath
- ☐ Blisters on lips or mouth
- ☐ Cigarette, pipe, or cigar smoking
- ☐ Smokeless Tobacco
- ☐ Dry mouth
- ☐ Food Collection between teeth
- ☐ Clench or grind teeth
- ☐ Growths or sore spots in your mouth
- ☐ Gums swollen, tender or bleeding
- ☐ Head, neck, jaw pain, or aches
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Periodontal Treatment
- ☐ Sensitivity to pressure, cold, heat or sweets

Have you ever had an allergic reaction to Novocaine , local or general anesthetics? If Yes, please explain: ◯ Yes ◯ No

Have you ever had trouble from previous dental care? If Yes, please explain: ◯ Yes ◯ No

Medical History:

Physician's name: Physician's Phone:

Indicate which of the following you have had or have at present. By checking the box, it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ AIDS, HIV +
- ☐ ***Pre-Medication
- ☐ Abnormal bleeding
- ☐ Alcohol use/consumption
- ☐ Allergy - Latex
- ☐ Allergy - medications (Explain below)
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Bisphosphonates (Fosomax, Actonel, Boniva, Reclast, Didronel, Zometa ect.)
- ☐ Blood disease, clotting disorder
- ☐ Blood thinners, Other than Aspirin
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hepatitis type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Any immune deficiency
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnant/Nursing: Due Date: _____
- ☐ Radiation treatments Respiratory
- ☐ disease
- ☐ Rheumatic fever
- ☐ Seasonal Allergies, hay fever, sinusitis
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Sickle cell anemia
- ☐ Slow healing wounds
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid problems
- ☐ Tumor or growth on head/neck
- ☐ Ulcer
- ☐ Venereal disease
- ☐ Weight loss, unexplained
- ☐ Any hospitalization in the last 5 years
- ☐ **None**

All Patients: Are You Allergic To Or Have You Ever Had Any Reaction To The Following? (Check All That Apply): ☐ **None**

- ☐ Aspirin
- ☐ Anesthetic – Local
- ☐ Barbiturates
- ☐ Codeine
- ☐ Dairy
- ☐ Latex
- ☐ Lactose Intolerance
- ☐ Metal Sensitivity
- ☐ Nitrous Oxide Sedation
- ☐ Sleeping Pills
- ☐ Sulfa Drugs
- ☐ Penicillin/other Antibiotics
- ☐ Other – Please List: .....

Medication Information:

All Patients: Are You Allergic To Or Have You Ever Had Any Reaction To 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

Drug Name	Dosage	Reason Prescribed:

Authorization and Release: I have read and answered the above questions to the best of my knowledge

Patient/Guardian Signature **Date**

Doctor Signature **Date**

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Notice of information and Privacy Practices, HIPAA Communication Form:

Patient Name: _____ DOB:_____

I have been given a copy of Professional Dental Alliance practice ("Practice**"), *Notice of Information and Privacy Practices* ("**Notice**"), which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at (972) 231-5744.**

Patient privacy is important to us. Our policy to keep patient health information confidential and not disclose such information without your consent or written authorization unless otherwise required by federal or state privacy laws.

Please provide us with information with whom we can communicate with concerning your care. We would also like to obtain information regarding alternative communication preferences so that we know the best way to contact you with appointment reminders or other information related to your care.

Please note: If you have someone accompany you in the treatment area, we will assume this person is entitled to receive information regarding your care and we can freely discuss your health information.

You are free to make changes to your preferences at any time. Updates must be made in person and a new form completed.

Please provide the names and relationship to patient for those individuals you will need or want your health information to be provided. This includes family members, friends, organizations or caregivers/babysitters:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Patient Communication – Our practice is to protect the privacy of our patients while ensuring our patients are kept well informed of their appointments and other information. As a service to our patients, we will communicate appointment reminders and other information via text message, email or via phone. Limited information will be left when leaving a voice massage. Medical information will not be shared when leaving a voice message. Please inform our team if you would prefer we use an additional communication preference for appointment reminders or other information related to your care.

My signature below acknowledges that I have been offered and/or provided with a copy of the Notice of Information and Privacy Practices:

_____

Patient, Guardian, or Personal Representative Signature **Date**

_____

Print Name and/or Personal Representative's Title (e.g., *Guardian, Executor of Estate, Health Care Power of Attorney)*