ACCOUNT NUMBER

PATIENT INFORMATION

TODAY'S DATE _____

NAME _____ HOW DO YOU WISH TO BE ADDRESSED? _____
First Middle Last

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ WORK PHONE _____ EXT _____

EMPLOYER _____ ADDRESS _____

ARE YOU A FULL TIME STUDENT? Y OR N (CIRCLE) SCHOOL _____

BIRTHDATE _____ SEX M OR F (CIRCLE) SOCIAL SECURITY # _____

SPOUSE'S NAME _____ WORK PHONE _____

RESPONSIBLE PARTY INFORMATION

FOR CHILDREN - FILL OUT BOTH PARENTS INFORMATION BELOW

NAME _____ HOME PHONE _____

ADDRESS _____ WORK PHONE _____ EXT _____
Street Apt. # City State Zip

EMPLOYER _____ SOCIAL SECURITY # _____

NAME _____ HOME PHONE _____

ADDRESS _____ WORK PHONE _____ EXT _____
Street Apt. # City State Zip

EMPLOYER _____ SOCIAL SECURITY # _____

ARE ANY OTHER FAMILY MEMBERS CURRENT PATIENTS AT THIS PRACTICE? _____

IF SO, WHO _____

IN CASE OF AN EMERGENCY, WHO CAN WE CONTACT BESIDES YOUR SPOUSE?

_____
Name Home Phone Work Phone Relationship to You

WHO CAN WE THANK FOR REFERRING YOU TO US? _____

DENTAL INSURANCE 1ST COVERAGE

INSURANCE COMPANY NAME _____

ADDRESS _____

GROUP # _____ EFFECTIVE DATE: _____

POLICYHOLDER NAME _____

POLICYHOLDERS: SOCIAL SECURITY # _____

BIRTHDATE _____

EMPLOYER _____

ADDRESS _____

_____
City State Zip

RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD OTHER (PLEASE CIRCLE)

DENTAL INSURANCE 2ND COVERAGE

INSURANCE COMPANY NAME _____

ADDRESS _____

GROUP # _____ EFFECTIVE DATE: _____

POLICYHOLDER NAME _____

POLICYHOLDERS: SOCIAL SECURITY # _____

BIRTHDATE _____

EMPLOYER _____

ADDRESS _____

_____
City State Zip

RELATIONSHIP TO POLICYHOLDER: SELF SPOUSE CHILD OTHER (PLEASE CIRCLE)

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

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

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

REGISTRATION

REORDER # 0803571

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the used and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as describes in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Shirene Orandi, D.D.S.**

Telephone: **(651) 688-3545** Fax: **(651) 688-8650**

Email: **shireneorandidds@yahoo.com**

Address: **4178 Knob Drive, Suite D, Eagan MN 55122**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you of you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the consents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

ACCOUNT NUMBER

PATIENT NAME _____ **BIRTHDATE** _____
First Middle Initial Last

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit date: _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a daily basis? _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Are you unhappy with the appearance of your teeth? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you clench or grind? _____ Yes No
Have you had problems with past dental treatments? _____ Yes No
Name of previous dentist (optional): _____ Address: _____
Date of last full mouth x-rays or panorex: _____
Date of last bite wing x-rays: _____
Do you prefer to have local anesthetic (novocaine) and/or nitrious oxide (laughing gas) for dental treatment? PLEASE CIRCLE
Do you have well water, drink bottled water or have a water filter that removes fluoride from your water? PLEASE CIRCLE

Medical History

Physician Name: _____ Phone: _____ Address: _____
Has there been any change in your health in the past year? _____ Yes No
Have you been under a physicians care in the past 2 years? Who? _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs, prescription or non-prescription? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Local Anesthetics (Novocaine) ☐ Other _____
Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

***If yes to any of the starred conditions, please call prior to your appointment . . . Premedication may be required**

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	☐	☐	Bruise Easily	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐	Glaucoma	☐	☐
* Heart Murmur	☐	☐	Anemia	☐	☐	Cancer	☐	☐	Renal Dialysis	☐	☐	Tumors or Growths	☐	☐
Irregular Heart Beat	☐	☐	Excessive Bleeding	☐	☐	X-Ray Treatments (Radiation)	☐	☐	Thyroid Disease	☐	☐	Psychiatric Care	☐	☐
Angina/Chest Pain	☐	☐	Sickle Cell Disease	☐	☐	Chemotherapy	☐	☐	Parathyroid Disease	☐	☐	Alzheimer's Disease	☐	☐
Heart Attack/Failure	☐	☐	Hemophilia (Bleeding)	☐	☐	Stomach/Intestinal Disease	☐	☐	Arthritis/Gout	☐	☐	Allergies (Medicines)	☐	☐
Congenital Heart Disorder	☐	☐	Leukemia	☐	☐	Ulcers	☐	☐	Rheumatism	☐	☐	Allergies (Pollen/Dust)	☐	☐
* Mitral Valve Prolapse	☐	☐	Blood Transfusion	☐	☐	Weight Loss/Gain	☐	☐	Cortisone Medicine	☐	☐	Hives or Rash	☐	☐
Scarlet Fever	☐	☐	Swelling of Limbs	☐	☐	Frequent Diarrhea	☐	☐	AIDS	☐	☐	Smoke or Chew	☐	☐
* Rheumatic Fever	☐	☐	Lung Disease	☐	☐	Diabetes	☐	☐	HIV Positive	☐	☐	Bulimia/Anorexia	☐	☐
* Artificial Heart Valve	☐	☐	Breathing Problem	☐	☐	Excessive Thirst	☐	☐	Cold Sores	☐	☐	Contact Lenses	☐	☐
* Heart Pace Maker	☐	☐	Shortness of Breath	☐	☐	Hypoglycemia	☐	☐	Fever Blisters	☐	☐	Alcoholism	☐	☐
* Heart Surgery	☐	☐	Frequent Cough	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐	Drug Abuse/Addiction	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐	Hepatitis A (Infectious)	☐	☐	Convulsions	☐	☐			
Low Blood Pressure	☐	☐	Asthma	☐	☐	Hepatitis B or C (Serum)	☐	☐	Epilepsy or Seizures	☐	☐			
* Artificial Joint	☐	☐	Emphysema	☐	☐	Yellow Jaundice	☐	☐	Fainting or Dizziness	☐	☐			

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change. I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____
History Review and Significant Findings: _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____

SHIRENE ORANDI D.D.S. FAMILY DENTISTRY
PAYMENT OPTIONS

We believe that patients who come to this office want and deserve the best dental care we can provide. We offer you the following options to help make dentistry more affordable for you and your family.

Payment Options:

1) Pay in full at the time of service, with a check, and receive a 5% savings
2) MasterCard, Visa, Discover, American Express or CareCredit
3) An office payment plan (usually half down and two monthly payments…Our staff will be glad to help you work out a plan suitable for your budget)
4) Insurance patients: we will be happy to process your insurance for you but ask that you pay your estimated portion at the time of service or make other suitable arrangements on that portion.

NAME OF ACCOUNT GUARANTOR:

_____ SOC. Security #: _____

I (we) willingly provide the above information for the purpose of obtaining credit. I (we) agree to be bounded by the terms of your credit policy:

*The account balance shown on each statement is due and payable in full within 30 days. Financial arrangements may be made with the business office if necessary.

*A finance change will be computed by a Periodic Rate of 1-1/2%, which is an Annual Percentage Rate of 18%. The finance charge will begin to accrue on balances that are 60 days and older.

*If the account balance becomes delinquent, the collection agency and/or court fees will be the responsibility of the patient or account guarantor.

If you have insurance, we will assist you in filing the necessary forms. However, we assume no responsibility for payment by any third party. Your insurance plan is an agreement between you and your insurance company. While we will cooperate to the fullest in expediting your claim, YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT.

SIGNATURE: _____ DATE: _____

Record Release Form

Coming to our office

Shirene Orandi DDS, PA
Family Dentistry
(651)688-3545
4178 Knob Drive
Eagan, MN 55122

I, _____am authorizing _____to release all viable records to Dr. Orandi's office.

Please e-mail x-rays to office@shireneorandidds.com if possible.

Also, please release records for my following family members:

_____	_____
(Name)	(Date of birth)
_____	_____
(Name)	(Date of birth)
_____	_____
(Name)	(Date of birth)
_____	_____
(Name)	(Date of birth)
_____	_____
(Name)	(Date of birth)

_____

(Signature) **(Date)**

Reason for leaving office_____

_____