PAUL VARTABEDIAN, DDS
Prosthetic, Cosmetic & Implant Dentistry
YOUR SMILE. OUR PASSION.

# PATIENT INFORMATION

Patient Name: ____________________ ____________________ ___ ____________________
Last First MI Preferred Name

Gender: M/F Family Status: Married/Single/Child/Other Date of Birth: ____________

SS#______-_____-______ Email Address: ____________________

Home phone: ______________ Mobile phone: ______________ Work phone: ______________

Address: ____________________ ____________________
Mailing Physical- if different

____________________ __________ __________
City State Zip Code

Whom may we thank for referring you to our practice? ____________________

Emergency Contact: ____________________ Phone number: ____________________

**(PARENT/LEGAL GUARDIAN ACCOMPANYING MINOR)**

First Name: ______________ Last Name: ______________ Relation to Patient: __________

Date of Birth: __________ SS#______-______-_________ Employer: ____________________

Address: ____________________ City, State, Zip ____________________

Home phone: ______________ Mobile phone: ______________ Work phone: ______________

## HIPAA Acknowledgement

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health information (PHI) for the purposes of treatment, payment, and health care operations as described in the Privacy Notice (Health Insurance Portability & Accountability Act)

**Signature:** ____________________ **Date:** ____________________

Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other (specify) ____________________

Apart from your insurance and treating physicians, HIPAA restricts us from disclosing information to ANYONE without your written consent. If you wish to authorize release of information to someone (parent, spouse, child, friend, etc.) please let us know:

Name: ____________________ Relation: ____________________

Name: ____________________ Relation: ____________________

Patient Name: _____________________ ___________________________
Last First

**CONSENT (please initial below):**

______ I authorize the doctor and staff to perform any dental treatment mutually agreed upon, with the use of the agreed upon anesthetics and/or medications if necessary. I fully understand the risks/benefits/alternatives to treatment provided, and can discuss these at any time before, during, and/or after treatment. I have reviewed and can request a copy of the “Notice of Privacy Practices Sheet” and “Facts about Fillings Sheet.” I can ask questions at any time regarding this information. The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my/my child’s physician.

______ I authorize the doctor and staff to request my records from my previous dental/specialist offices, if needed.

______ I understand that **payment is due at the time of service**, and if payment is not received by agreed upon dates, I will be responsible for any finance charges accrued. For dental insurance Dr. Vartabedian is a provider for, I authorize and request my insurance company to pay directly to the dentist otherwise payable by me. I agree to be responsible for any costs not paid by insurance. **I understand that if Dr. Vartabedian is not an in-network provider for my dental insurance, I will be responsible for paying the full amount of services rendered at the time of service. As a courtesy to me, they will bill my dental insurance and I will receive payment from my dental insurance directly.** The costs estimates I am given are only estimates and unforeseen events may cause a change in the cost for my treatment.

______ I understand the appointments I schedule are held for me. Should I need to cancel or reschedule, I understand that I need to give notice **7 DAYS prior** to appointments for non-preventative procedures or **3 DAYS prior** to preventative appointments (check-up exams, xrays, dental cleanings). **A broken-appointment fee of up to 50% of the treatment amount scheduled** for any appointment missed or cancelled without the **above-required** notification may be applied.

By signing below, I understand and agree to the terms above.

**Patient/Guardian Signature:** ____________________________________ **Date:** __________________________

**PRIMARY INSURANCE: Please enter *Subscriber* Information below:**

First Name: ___________________________ Last Name: _______________________ Relation to Patient: ____________

Date of Birth: _____________ SS#______-______-_________ Employer: __________________________________________

Insurance Company Name: __________________________________ Insurance Phone Number: _____________________________

**SECONDARY INSURANCE (if applicable): Please enter *Subscriber* Information below:**

First Name: ___________________________ Last Name: _______________________ Relation to Patient: ____________

Date of Birth: _____________ SS#______-______-_________ Employer: __________________________________________

Insurance Company Name: __________________________________ Insurance Phone Number: _____________________________