Aesthetic Dentistry, P.C.

Vahid Varasteh, D.M.D.
Mina Kalali, D.M.D.

CONFIDENTIAL PATIENT INFORMATION

PERSONAL INFORMATION ***DATE:***_____

Name: _____ *E-Mail* _____

*Address*_____
STREET *CITY* *STATE* *ZIP*
Telephone: Home: _____ *Business* _____ *Cell*_____

Birthdate: _____ *Sex:* _____ *Marital Status:* _____ *Spouse Name*_____

Occupation: _____ *Referred by:* _____

*Reason for visit*_____

Last Dental Visit _____ *Seen by* _____
NAME *ADDRESS*
Personal Physician: _____ *Phone*_____

Pharmacy Name: _____ *Phone*_____

HEALTH INFORMATION

YES ***NO***

☐ ☐ *1. Have you been hospitalized within the past 2 years? For what?* _____

☐ ☐ *2. Are you currently being treated by a physician? For what?*_____

☐ ☐ *3. Are you currently taking any medicines or drugs? What?* _____

☐ ☐ *4. Are you allergic to any drugs? What?* _____

☐ ☐ *5. Are you allergic to Latex?* _____

☐ ☐ *6. Are you allergic to any metals? What?* _____

☐ ☐ *7. Have you ever had a skin rash or other reaction? From what?* _____

☐ ☐ *8. Do you bleed excessively upon injury?* _____

☐ ☐ *9. Are you pregnant? Due Date?* _____

CIRCLE ANY OF THE FOLLOWING CONDITIONS WHICH YOU HAVE HAD

A. AIDS
B. Arthritis
C. Asthma
D. Cancer
E. Diabetes
F. Epilepsy
G. Glaucoma
H. Heart Murmur
I. Heart Problem
J. Hepatitis
K. High Blood Pressure
L. Jaundice
M. Kidney Problems
N. Low Blood Pressure
O. Nervous Breakdown
P. Psychiatric Therapy
P. Rheumatic Fever
Q. Sexually Transmitted Diseases
R. Stroke
S. Tuberculosis
T. Drug or Alcohol Use
U. Other Diseases
Please Specify: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship_____ SS#_____

Address: _____
STREET CITY STATE ZIP

Telephone: Home: _____ Business_____

DENTAL INSURANCE INFORMATION

Primary Insurance Co.: _____
NAME ADDRESS

Employee: _____ Relationship:_____ ID#_____

Employer: _____ Group#_____

Secondary Insurance Co._____
NAME ADDRESS

Employee: _____ Relationship_____ SS#_____

Employer: _ _____ Policy #_____

I understand that payment is my obligation regardless of insurance or any other third party involvement . There will be a charge for appointments cancelled or broken without 24 hrs. notice.

Signature: _____ *Date:*_____

PERSON TO BE CONTACTED IN AN EMERGENCY

_____
NAME ***ADDRESS*** ***PHONE#***

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Mission Statement:

"OUR MISSION IS TO IMPROVE THE LIVES OF OUR PATIENTS THROUGH DEDICATION AND COMMITMENT TO EXCELLENCE IN DENTISTRY."

Consent Form

I hereby authorize the Doctors at Aesthetic Dentistry to take any necessary x-rays, study models, images, or any other diagnostic aids needed to make a thorough diagnoses of my dental needs.

I also authorize the Doctors at Aesthetic Dentistry to perform any necessary treatment, prescribe medications and therapy that may be indicated after being discussed with me.

I understand that I will be responsible for the cost associated with services that have been provided for me. If applicable, Aesthetic Dentistry will bill my dental insurance company. I will remain responsible for any co-payments or services not covered at the time of my visit unless other financial arrangements have been made. I understand that any unpaid balance will be subject to finance charges.

Name _____ Date_____

(Signature)

240 Main Street North Reading, Massachusetts 01864 Phone (978) 664-5901

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***PAYMENT IS DUE AT THE TIME SERVICES RENDERED**

In order to provide services which are financially manageable to our patients,

We offer the following options for payment:

Cash, check or Credit Card (Visa, MC, Amex and Discover)

Care Credit

Insurance Submittals

We will be happy to submit charges to your insurance carrier with advance notice of coverage. If we are unable to verify insurance coverage prior to your appointment we will gladly provide a paid receipt for direct reimbursement. When submitting insurance, the estimated uncovered portion is due on the day of treatment. Any balance not covered by your insurance company is your responsibility. All insurances over 60 days will be transferred to your account at which time we will notify you of your responsibility for payment.

YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. It is your responsibility to know your insurance coverage. We will do our best to accurately estimate your out of pocket expenses, although you are ultimately responsible for all treatment charges.

The parent that accompanies a minor to a dental visit is the person responsible for payment.

In order for the dental laboratory to fabricate any dental appliance or prosthesis, a minimum of 50% down. Payment will be required at the time of first visit. The remaining balance will be due upon delivery.

Our schedule is designed with you in mind. Appointment times are specifically reserved for you with your provider. **If you have to reschedule your appointment, please call us as soon as possible, so we can accommodate other patients. There will be a charge of $100 for no shows and rescheduling with less than 24 hour notice.**

Account Balances over 30 days are subject to a finance charge

I have read and understand Aesthetic Dentistry's policy _____

Initial Here

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