MARY GHARAGOZLOO
DDS

338 N Magnolia Ave Suite A Orlando FL 3280 407.648.3688 marygdds@securedds.com www.marygdds.com

Patient Name: Last First MI Preferred Name

Title: Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: SS #

Email Address:

Phone: Home Work Ext Fax Other

Address:
City State Zip Code

How would you like us to contact you?

The following is for: ☐ The patient ☐ The person responsible for the payment

Employer Name: Phone:

Address:
City State Zip Code

Who may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Do you require premedication prior to treatment? If so, which medication?

Primary Dental Insurance:

Name of Insured: Last First MI

Insured's Birth Date: ID #. Group #.

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Insurance Company Phone Number:

Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

MARY GHARAGOZLOO
DDS

Mary Gharagozloo DDS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Mary Gharagozloo, DDS this ____day of ____________, 20__ . A copy of this signed, dated Acknowledgement shall be as effective as the original.

____
Please print your name

____
Please sign your name

If you are the legal representative of the patient, please print the patient's name and describe your authority____

Thank you and if you have any questions about this form or the attached Notice, please contact our Privacy Official.

Office Use Only

As Privacy Official, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign
because (please describe) ____________________

MARY GHARAGOZLOO
DDS

Financial Agreement

Payment

Payment is expected at the time of service. If you have dental insurance, as a courtesy we will file and accept assignment of benefits as well as collect your estimated portion at the time of service. Dr. Gharagozloo is an out-of-network provider for all dental insurance plans. Your insurance policy is a contract between you and your insurance company, therefore, any unpaid balance is your responsibility.

We provide a variety of payment options. We accept cash, checks, all major credit cards and offer third party financing through Care Credit. Our patient facilitator will be glad to discuss these options with you at any time.

We ask that if your sending a child to our office without a parent that you plan for payment either prior to the appointment or by sending a form of payment along with the child.

Reservations & Cancellations

We do understand that emergencies happen and schedules change. We do ask that if you cannot make your appointment, to please notify us within 48 hours so that we can plan to fill your spot with another patient. A fee will be charged to your account for any canceled appointments within 48 hours notice. Our fee schedule is as follows: $50.00 for the first cancellation or no show. $75.00 for the second, and the full value of the appointment missed for the third.

By signing below, I agree to above terms and conditions.

______________________________________ _______________

Patient or Responsible Party signature Date

MEDICAL HISTORY

Patient Name ______________________ Nickname ____________ Age ____________

Name of Physician/and their specialty ______________________

Most recent physical examination ______________ Purpose ______________

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury ______ ☐ ☐
2. an allergic or bad reaction to any of the following: ☐ ☐
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ chlorhexidine (CHX)
   - ☐ metals (nickel, gold, silver, ______________)
   - ☐ latex ______
   - ☐ nuts ______
   - ☐ fruit ______
   - ☐ other ______
3. heart problems, or cardiac stent within the last six months ______ ☐ ☐
4. history of infective endocarditis ______ ☐ ☐
5. artificial heart valve, repaired heart defect (PFO) ______ ☐ ☐
6. pacemaker or implantable defibrillator ______ ☐ ☐
7. orthopedic implant (joint replacement) ______ ☐ ☐
8. rheumatic or scarlet fever ______ ☐ ☐
9. high or low blood pressure ______ ☐ ☐
10. a stroke (taking blood thinners) ______ ☐ ☐
11. anemia or other blood disorder ______ ☐ ☐
12. prolonged bleeding due to a slight cut (INR > 3.5) ______ ☐ ☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ______ ☐ ☐
14. chronic ear infections, tuberculosis, measles, chicken pox ______ ☐ ☐
15. asthma ______ ☐ ☐
16. breathing or sleep problems (e.g., sleep apnea, snoring, sinus) ______ ☐ ☐
17. kidney disease ______ ☐ ☐
18. liver disease ______ ☐ ☐
19. jaundice ______ ☐ ☐
20. thyroid, parathyroid disease, or calcium deficiency ______ ☐ ☐
21. hormone deficiency ______ ☐ ☐
22. high cholesterol or taking statin drugs ______ ☐ ☐
23. diabetes (HbA1c = ______) ______ ☐ ☐
24. stomach or duodenal ulcer ______ ☐ ☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ______ ☐ ☐

YES NO

26. osteoporosis/osteopenia (e.g., taking bisphosphonates) ______ ☐ ☐
27. arthritis ______ ☐ ☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) ______ ☐ ☐
29. glaucoma ______ ☐ ☐
30. contact lenses ______ ☐ ☐
31. head or neck injuries ______ ☐ ☐
32. epilepsy, convulsions (seizures) ______ ☐ ☐
33. neurologic disorders (ADD/ADHD, prion disease) ______ ☐ ☐
34. viral infections and cold sores ______ ☐ ☐
35. any lumps or swelling in the mouth ______ ☐ ☐
36. hives, skin rash, hay fever ______ ☐ ☐
37. STI/STD/HPV ______ ☐ ☐
38. hepatitis (type ____) ______ ☐ ☐
39. HIV/AIDS ______ ☐ ☐
40. tumor, abnormal growth ______ ☐ ☐
41. radiation therapy ______ ☐ ☐
42. chemotherapy, immunosuppressive medication ______ ☐ ☐
43. emotional difficulties ______ ☐ ☐
44. psychiatric treatment ______ ☐ ☐
45. antidepressant medication ______ ☐ ☐
46. alcohol/recreational drug use ______ ☐ ☐

ARE YOU:

47. presently being treated for any other illness ______ ☐ ☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) ______ ☐ ☐
49. taking medication for weight management ______ ☐ ☐
50. taking dietary supplements ______ ☐ ☐
51. often exhausted or fatigued ______ ☐ ☐
52. experiencing frequent headaches ______ ☐ ☐
53. a smoker, smoked previously or use smokeless tobacco ______ ☐ ☐
54. considered a touchy/sensitive person ______ ☐ ☐
55. often unhappy or depressed ______ ☐ ☐
56. taking birth control pills ______ ☐ ☐
57. currently pregnant ______ ☐ ☐
58. diagnosed with a prostate disorder ______ ☐ ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) ______________________

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ____________

Doctor's Signature ______________________ Date ____________

ASA ______ **(1-6)** ○ ○ ○

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DENTAL HISTORY

Patient Name ______________________ Nickname ______________________ Age ________

Referred by ______________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist ______________________ How long have you been a patient? ______________ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ______________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	☐ ☐ ☐	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]		☐	☐
2. Have you had an unfavorable dental experience?		☐	☐
3. Have you ever had complications from past dental treatment?		☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?		☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?		☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?		☐	☐

GUM AND BONE	☐ ☐ ☐	YES	NO
7. Do your gums bleed or are they painful when brushing or flossing?		☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?		☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?		☐	☐
10. Is there anyone with a history of periodontal disease in your family?		☐	☐
11. Have you ever experienced gum recession?		☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?		☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?		☐	☐

TOOTH STRUCTURE	☐ ☐ ☐	YES	NO
14. Have you had any cavities within the past 3 years?		☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?		☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?		☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?		☐	☐
18. Do you have grooves or notches on your teeth near the gum line?		☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		☐	☐
20. Do you frequently get food caught between any teeth?		☐	☐

BITE AND JAW JOINT	☐ ☐ ☐	YES	NO
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)		☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?		☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?		☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?		☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?		☐	☐
26. Are your teeth developing spaces or becoming more loose?		☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?		☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?		☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?		☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?		☐	☐
32. Do you wear or have you ever worn a bite appliance?		☐	☐

SMILE CHARACTERISTICS	☐ ☐ ☐	YES	NO
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?		☐	☐
34. Have you ever whitened (bleached) your teeth?		☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?		☐	☐
36. Have you been disappointed with the appearance of previous dental work?		☐	☐

Patient's Signature ______________________ Date ________

Doctor's Signature ______________________ Date ________

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