Mehregan Dental Corporation

Quality Dentistry - Downey

10558 Paramount Blvd, Downey, CA 90241 | (562) 869-2091

Patient Registration

Please print clearly. Complete the sections that apply to you and bring this packet to your appointment. Ask our team if you need help with any question.

Patient information

Patient name (last, first, middle): _____

Preferred name: _____ Title: _____

Birth date: _____ Gender: _____ SS#: _____

Family status: ☐ Married ☐ Single ☐ Child ☐ Other

Email: _____ Best time to call: _____

Home phone: _____ Mobile phone: _____

Work phone / extension: _____ Other phone / fax: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Employer: _____ Employer phone: _____

Employer address: _____

Referred by: _____

Emergency contact / relationship: _____ Phone: _____

Responsible party (if different from patient)

Name / relationship to patient: _____

Birth date: _____ SS#: _____ Driver license #: _____

Address: _____

Email: _____ Phone: _____

Employer / phone: _____

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Insurance & Dental History

Primary dental insurance (if applicable)

Name of insured: _____ Birth date: _____

Insurance company / plan: _____

Member ID: _____ Group #: _____

Patient relationship to insured: _____

Insured address: _____

Insured employer / address: _____

Insurance company address: _____

Insurance company phone: _____

Dental history

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

Previous dentist / phone: _____

Date of most recent dental exam and X-rays: _____

I usually visit the dentist: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

What is your immediate concern? _____

What would you like to change about your smile? _____

Check any that apply

- ☐ Complications from past dental treatment
- ☐ Trouble getting numb
- ☐ Reaction to local anesthetic
- ☐ Braces or orthodontic treatment
- ☐ Dry mouth
- ☐ Teeth sensitive to hot, cold, sweets or biting
- ☐ Teeth whitening or bleaching
- ☐ Jaw popping or clicking
- ☐ Difficulty chewing
- ☐ Clenching or grinding teeth
- ☐ Worn a mouth or bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Gum disease treatment or bone loss
- ☐ Unpleasant taste or breath
- ☐ Gum recession
- ☐ Loose teeth without injury
- ☐ Burning mouth sensation
- ☐ Sore or ulcer that keeps returning

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Additional Information & Financial Policy

Patient name: _____

Please explain any checked dental history items

_____

_____

Insurance authorization

I authorize my insurance company to pay the dentist all insurance benefits rendered. 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.

Patient or parent/guardian signature: _____ Date: _____

Printed name: _____

Consent for services and financial policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further time or condition and I further agree to pay all costs and reasonable attorney's fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

By signing below, I acknowledge the above information and agree with its contents.

Patient or parent/guardian signature: _____ Date: _____

Printed name: _____

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Cancellation Policy & HIPAA Acknowledgment

Cancellation policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 working hours in advance.

Any appointments that are cancelled without 48 hour notice are considered late cancellations. Those with multiple late cancellations will be treated as a no show. All late cancellations and no show appointments will be recorded in the patient's chart. Multiple Late Cancellation/No Show fees of $50.00 may be billed to the patient for each no show appointment and/or for multiple late cancellations.

To cancel or reschedule an appointment, please call (562) 869-2091 during office hours: Monday and Wednesday, 9 AM-6 PM; Tuesday and Thursday, 8 AM-5 PM. Friday, Saturday and Sunday closed.

Our doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

By signing below, I acknowledge the above information and agree with its contents.

Patient or parent/guardian signature: _____ Date: _____

Printed name: _____

HIPAA acknowledgment

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that I may refuse to sign this authorization and that my treatment or payment for my health care will not be affected by this authorization that I have signed.

I understand that if information is used or disclosed pursuant to this authorization, the information could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting confidentiality.

By signing below, I acknowledge the above information and agree with its contents.

Patient or parent/guardian signature: _____ Date: _____

Printed name: _____