Welcome!

Mission Dental Implant Center and Periodontal Care
(949) 364-2935 • (949) 364-2870 FAX
26800 CROWN VALLEY PKWY, #425
MISSION VIEJO, CA 92691
WWW.MISSIONIMPLANTCENTER.COM

1.

Today's Date: _____/ _____/ _____

Patient Name:

_____
LAST FIRST MI (PREFERRED)

Date of Birth: _____/ _____/ _____ Age: _____ Social Security Number: _____

Mailing Address: _____
CITY STATE ZIP

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____ Referred By: _____

Employer: _____ How Long? _____

Employer Address: _____
CITY STATE ZIP

Occupation: _____ Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name: _____ Do you have children? ☐Yes ☐No How many? _____

2. PRIMARY DENTAL INSURANCE

Company Name: _____ Address: _____

Phone: _____ Group #: _____ Insured's SS#: _____

Insured's Name: _____ Relation: _____ Date of Birth: _____/ _____/ _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Company Name: _____ Address: _____

Phone: _____ Group #: _____ Insured's SS#: _____

Insured's Name: _____ Relation: _____ Date of Birth: _____/ _____/ _____

Insured's Employer: _____

3. PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT

Name: _____ Relation: _____

Billing Address: _____
CITY STATE ZIP

Initials: _____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

4. IN EVENT OF EMERGENCY

Whom should we contact? _____ Relation: _____

Home Phone: _____ Work Phone:

_____

5. PHARMACY INFORMATION *Beginning January 2022, all RXs will be electronic, below info is required.

Pharmacy Name: _____ Phone Number: _____

Address: _____
CITY STATE ZIP

Health History

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Patient Name:

_____

LAST FIRST MI (PREFERRED NAME)

Indicate which of the following you have had or have presently. By checking the box you will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐*Pre-Med - Amox	☐*Pre-Med - Clin	☐*Pre-Med - Other	☐Allergy - Aspirin
☐Allergy - Codeine	☐Allergy - Erythro	☐Allergy - hay Fever	☐Allergy - Latex
☐Allergy - Other	☐Allergy - Penicillin	☐Allergy - Sulfa	☐Alzheimer's/ Dementia
☐Anemia	☐Arthritis	☐Artificial Joints	☐Asthma
☐Autoimmune Disease	☐Blood Disease	☐Blood Pressure - High	☐Blood Pressure - Low
☐Blood Thinners	☐Cancer	☐Depression/ Anxiety	☐Diabetes Type I/ II
☐Dizziness/ Fainting	☐ Emphysema/ COPD	☐Epilepsy/ Seizures	☐Excessive Bleeding
☐Glaucoma	☐Head/ Neck/ Jaw Injury	☐Heart Disease	☐Heart Murmur
☐Hepatitis A/B/C	☐HIV/ AIDS	☐Jaundice	☐Kidney Disease
☐Liver Disease	☐Mood Elevators	☐Nervous Disorders	☐Other
☐Pacemaker/ Stents	☐Parkinson's Disease	☐Psychiatric Care	☐Radiation/ Chemo
☐Respiratory Problems	☐Rheumatic Fever	☐Rheumatism	☐Sinus Problems
☐STD/ HPV	☐Stomach Problems	☐Stroke	☐Thyroid Condition
☐Tuberculosis	☐Tumors/ Growths	☐Ulcers	☐Wheelchair Bound

* WOMEN ONLY: ☐Pregnant/ Planning Pregnancy/ Nursing
If yes, when is the due date?_____

Please clarify the conditions or alerts selected:

_____

_____

Do you have any other health issues or allergies?

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain* ○Yes ○No
Pre-Med:

_____

_____

What is the reason for your dental visit today?

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

Describe any current medical treatment, recent hospitalizations and recent or impending surgery.

_____

_____

Name, address, and phone number of Primary Care Physician/ Medical Doctors:

_____

_____

Name, address, and phone number of General Dentist:

_____

_____

Are you taking any medications (prescription and non-prescription)? If yes, please explain below *

○Yes ○No

Medications:

_____

_____

_____

_____

_____

_____

Do you have any upcoming surgery plans? If yes, please explain below * ○Yes ○No

☐***By checking this box, I acknowledge that I have reviewed ALL questions/ alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/ allergies that have not been listed. I am aware that I must notify the practice of any future changes. I further consent to the performance of x-rays and oral examinations. This will serve as my signature.**

Name of Patient/ Parent or Guardian completing this form*:

_____

Signature:

_____ **Response Date: _____/_____/_____**

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AL MANESH, D.M.D., INC.
PERIODONTIST

- COMPUTER-AIDED IMPLANT PLACEMENT
- PLASTIC PERIODONTAL SURGERIES
- COSMETIC GUM SURGERIES
- IMPLANT DENTISTRY
- PERIODONTAL CARE
- BONE GRAFTING
- CT SCAN

AMERICAN ACADEMY OF IMPLANT DENTISTRY

FELLOW, INTERNATIONAL CONGRESS OF ORAL IMPLANTOLOGISTS

AMERICAN ACADEMY OF PERIDONTOLOGY

ACADEMY OF OSSEOINTEGRATION

AMERICAN DENTAL ASSOCIATION

ORANGE COUNTY DENTAL ASSSOCIATION

"Creating aesthetic excellence"

INSURANCE AND FINANCIAL POLICY

At Mission Dental Implant Center, we believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients; some have dental benefits, some do not. If you have dental benefits—congratulations! You are very fortunate. Here are some important things you should know:

Your dental benefits are based upon a contract made between your employer and insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay completely for your dental care, they are only meant to assist you.

We currently accept all private care insurance plans and most managed care plans. This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We "estimate" your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a "Pre-Treatment Authorization" with your insurance company prior to treatment. This does delay treatment, but it will give you the more exact out-of-pocket figure that you may require. Even with a pre-treatment authorization on file, insurance companies still stress that **every claim is subject to review upon completion.**

We will bill your insurance company as a courtesy. If your insurance does not pay within 90 days, Mission Dental Implant Center reserves the right to request payment in full from you, and let you collect the insurance funds that are due. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU AND YOUR INSURANCE COMPANY. Our office is not, and cannot be, a part of that legal contract. Dental x-rays may need to be taken during your appointment in order to properly diagnose your treatment, regardless of whether x-rays were taken at your general dentist's office. Our office will try to maximize your insurance benefits but if your insurance company does not pay for them, you will be responsible for the balance. Ultimately, you are responsible for all charges incurred in our office. Accounts with an outstanding balance over 60 days are subject to a 2.0% finance charge each billing cycle. If your account balance remains unpaid for 90 days following the date of service, it will be forwarded to a collection agency. All additional fees incurred by our office as a result of utilizing a collection agency's services will be the responsibility of the patient.

Mission Dental Implant Center requires payment in full for your portion of the balance at the time of service. We accept American Express, Discover, MasterCard, Visa, cash, checks, (for existing patients with established payment history). If you are in need of an extended financing option, we also offer Care Credit financing, which is a 12-month interest-free payment plan. Just ask one of our team members for an application.

Broken Appointments: A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least ONE WEEK notice for all surgeries to avoid a cancellation fee of $150 (covers the cost of materials prepared for your surgery). Additionally, due to the limited amount of time our hygienist is in the office, we require at least one week's notice to cancel or change a hygiene appointment to avoid a $50 broken appointment charge.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you have always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Print Name:_____

Signature: _____ Date: _____

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ACKNOWLEDGMENT

This form acknowledges your receipt of the HIPAA Notice of Privacy Practices as provided by our office. The HIPAA Notice of Privacy Practices describes how your protected health information may be used and disclosed.

Print Name: _____

Signature:_____

Date: _____

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INFORMED CONSENT FOR i-CAT CT SCAN

A CT scan is required to diagnose your periodontal condition and/ or implant eligibility. The fee listed below applies only to CT scans that are kept at Mission Dental Implant Center.

Procedure	**Fee**
Cone Beam-3D, Full Mouth	.00
Total	**.00**

A CT scan is not a "basic x-ray;" it requires the use of advanced technology. Dr. Manesh is one of few dental practitioners in Orange County who has the equipment and skill to provide this service. Additionally, the information provided in a CT scan is very unique from the information provided in an x-ray, including bone level and density and the location of the sinuses, which are pertinent pieces when determining treatment plan.

If you would like a reproduction of the CT scan as well as the valuable information provided with it, there is a fee of **$250.00**

Print Name: _____

Patient/ Guardian Signature: _____ Date: _____