Sarina Soumeeh DMD, Inc

Patient Registration Form

Patient Information

First Name: ____________________ Last Name:_________________ M.I. : _______ Sex: ☐Male ☐Female
SSN: ________________Driver Lic: ___________________Birth Date:______________ Age: _____________
Address: ____________________________________ City, State, Zip: ________________________________
Marital Status: ☐ Married ☐Single ☐Divorced ☐Separated ☐Widowed

Contact Information

Home Phone:______________Cell Phone:_______________Work Phone:____________ ext.____________
Email:
Employer Name: ________________________________ Web Address: _______________________________
Address: ______________________________________ City, State, Zip: _______________________________

Emergency Contact

Name: ____________________ Phone: _____________________ Relationship: ______________________

How did you hear about our office? ____

Responsible Party Information

Who is Responsible for this account?

First Name: _______________________ Last Name: _____________________ M.I. : __________________
SSN: __________________ Driver Lic: _______________________ Birth Date: ______________________
Address: ___________________________________ City, State, Zip: _________________________________
Relationship to Patient: ______________________
Home Phone:______________ Cell Phone:______________ Work Phone: ___________ ext. ___________

Insurance Information

Primary Insurance Information

Name of Insured: _________________________ SSN/Insured ID#: ________________________________
Insured Birth Date: _______________________ Relationship to Patient: ___________________________
Employer Name: _________________________ Group # _______________________________________
Address: ________________________________ City, State, Zip: __________________________________
Insurance Company: _____________________ Address: _______________________________________
City ______________________________ State _____________________ Zip: ______________________

Secondary Insurance Information

Name of Insured: _________________________ SSN/Insured ID# : _______________________________
Insured Birth Date: _______________________ Relationship to Patient: ___________________________
Employer Name: _________________________ Group # _______________________________________
Address: ________________________________ City, State, Zip: __________________________________
Insurance Company: _____________________ Address: _______________________________________
City ______________________________ State _____________________ Zip: ______________________

Please keep in mind you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. You are ultimately responsible for the balance of your account for any professional services rendered. **Your estimated portion of the charges is due at the time of service.**

You allow direct insurance payment to be made to Sarina Soumeeh DMD, Inc. Payment may be rendered by cash, Visa, Amex, MasterCard, and check. We reserve the right to charge a $25.00 fee for all returned checks. We require a 48hr notice for any cancellations to avoid a $100 charge to your account. I certify that all information is true and correct to the best of my knowledge. I will notify you of any changes for the above information.

______________________________ ____________________________________ ______________________
Patient Name Patient Signature Date

______________________________ ____________________________________ ______________________
Parent/Guardian Name (if minor) Parent/Guardian Signature Date

Time 5:05 PM | Dr. Sarina Soumeeh | Date 6/21/2024

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No		
Do you use tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:___________

Sarina Soumeeh DMD, Inc

Dental History

Patient: ___________________________________ **Birth Date**: _________________________

Reason for today's visit: ____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe: ____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe: ____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No

If so, please describe: ____

Level of anxiety about seeing the dentist: _________________ (Least) 1 2 3 4 5 (Most)

Date of last dental exam: ____

Date of last professional cleaning: ____

Date of last -Xrays: ____

Previous dentist's name: ____

Why are you changing dentists? ____

What would you like to discuss with the dentist today? ____

—— Tooth Ache	—— Teeth Whitening	—— Partial/ Dentures	—— Missing Teeth
—— Gum Problems	—— Cosmetics	—— Braces/ Invisalign	—— Teeth Grinding
—— Bad Breathe	—— Crowns/ Bridges	—— Wisdom Teeth	—— Jaw Click/Pop
—— Sensitive Teeth	—— Second Opinion		

—— Other ____

____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Have you noticed any mouth odors or bad taste? ☐ Yes ☐ No

Do you bite your lips or cheeks frequently? ☐ Yes ☐ No

Are your teeth sensitive to heat/cold? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Do you still have your wisdom teeth? ☐ Yes ☐ No

Sarina Soumeeh DMD, Inc

Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with a high-quality dental care using only the best material and technology available today. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

As a courtesy to you, we will process all of your insurance claims. However, please remember that eligibility and benefits quoted by your insurance company are not a guarantee of payment.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time your dental service is provided. Your co-payment may be adjusted after payment is received from your insurance company. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.

Our office accepts cash, Master Card, and Visa. We reserve the right to charge a $25 fee for all payments returned for non-sufficient funds. We strive to accommodate the scheduling needs of our patients, and we will make every effort to keep your scheduled appointment on time. Failure to provide us with 48 hours advance notice or failure to show up for a scheduled appointment will result in a cancellation/no show fee of $100.
Any account balance over 30 days will be subject to a monthly billing charge of $10.

In the event of any claim, controversy, or dispute, the essential nature of which involves personal injury, malpractice or any tort, by patient, his dependents, whether or not minors, heirs at law or personal representatives against doctor, treating provider, or Sarina Soumeeh DMD, Inc, the sole methods for resolving such dispute shall be binding arbitration administered by the American Arbitration Association. Both parties are giving up their right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I understand that no other dentist other than the treating dentist is responsible for my dental treatment.

Any questions you may have, please do not hesitate to ask. We thank you for your cooperation and understanding.

Patient's Name: ___________________________________

Patient's signature: ________________________________ Date: ___________________

SARINA SOUMEEH DMD, INC
2101 Rosecrans Ave, Suite 1200,
El Segundo, CA 90245
P 310-640-3500

Cancellation Policy

At this time, we would like to kindly remind you of our cancellation policy that is being strictly enforced due to our limited availability.

Your appointment is a reservation and should be treated as such, therefore, we reserve the right to charge $100.00 for every failed or canceled appointment without a 48-hour notice.

Your reservation needs to be confirmed before 12pm on the business day prior to your scheduled time. If at that time your reservation has not been confirmed, it will automatically be canceled and will be offered to a patient on our waiting list.

Our office is only open for patient care on Mondays, Wednesdays, and Fridays from 9am to 6pm. You can still communicate with our office on Tuesdays and Thursdays as these are our administration days and we are available to answer your call, email, or text.

We offer multiple ways of contacting our office. You may call us at (310) 640-3500, send us an email to info@adoredentalcare.com and of course you are always welcome to come directly into the office.

We understand emergencies happen and some things can be out of our control but we are trusting that our patients will inform us right away so that we can anticipate the changes in our schedule. We offer a 10-minute grace period for all reservations. If you happen to be running late, please inform us as soon as possible so that again, we can anticipate the changes in our schedule. We always strive to ensure that each patient receives the attention and care they deserve.

Your health is of our utmost priority. We know that you have a choice when it comes to choosing your dentist and we thank you for choosing us to care for you.

Patient Name: ____________________________ Date: ______________________

Patient Signature: ____________________________ Witness: ________________