



Ramin Homanfar, D.D.S.

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Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone (____) _____

Social Security: ____/____/____ Status: Married, Single, Divorced, and Other

Birthdate: _____

Cell: (____) _____ Other Phone: (____) _____

E-Mail: _____

Do you want your appointments confirmed by E-Mail: ____Y____N

Who may we thank for referring you: _____

In emergency who should we notify: _____

Phone: (____) _____

Primary Insurance Information:

Person Responsible for the account:

(Last) (First)

Employer: _____

Business Address: _____

Birth Date: _____ Social Security: _____

Insurance Company: _____

Phone number: (____) _____

Name of Dependents under this plan:



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Check if have any of the following:

- Bad Breath
- Bleeding gums
- Clicking/Popping jaw
- Food collection between teeth
- Grinding teeth
- Loose tooth or filling
- Periodontal treatment
- Sensitivity to cold/hot
- Sensitivity to Sweets
- Sores or growths in mouth

Please check if you have any of the following:

- Allergic to Anapsine
- Allergic to Compazin
- Allergic to Vicodin
- Allergies
- Anemia
- Anesthetic Allergy
- Antibiotic Allergy
- Arthritis
- Artificial Joints
- Aspirin Allergy
- Asthma
- Blood Disease
- Cancer
- Codeine Allergy
- Diabetic
- Dizziness
- Epi
- Epilepsy
- Excessive Bleeding
- Fainting
- Glaucoma
- Growths
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis
- High Blood Pressure
- HI



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(Please check if have had any of the following):

- Jaundice
- Kidney Disease
- Latex Allergy
- Liver Disease
- Mental Disorders
- Mitral Valve Prolapse
- Nervous Disorder
- No Epi
- On Birth Control
- Other
- Pacemaker
- Penicillin Allergy
- Percocet Allergy
- Percodan Allergy
- Require Pre-Medication for Treatment
- Pregnant
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stomach Problems
- Stroke
- Sulfa allergy
- Taking Supplements or Herbs
- Take Aspirin daily
- Taking Coumadin
- Taking Medications
- Thyroid Problems
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease

Medications Currently Taking:

List Of Allergies:



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I, certify that I, and/or my dependent (s) have insurance with _____ and assign directly to Dr. Homanfar D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submission.

The above named dentist may use my health care information and may disclose such information to the above name insurance company (and any new insurance company with my knowledge) and the agents for such companies for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date of this agreement or when I no longer continue with the dentist-patient relationship with Dr. Homanfar.

I acknowledge that I understand and have the read the above conditions and payment stipulations and agree to their consent

I further consent to treatment being preformed by Dr. Homanfar and his staff with first my being notified of the treatment that will be preformed in advance to it being completed.

X _____
Signature of the patient, parent, guardian

Date: _____

Relationship to the patient: _____



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I.V. Sedation Notification

Patient that require I.V. Sedation will need to bill their own insurance companies for payment and they will be required to pay in full for all procedures prior to having the treatment done.

Due to the inability to see other patients at the time that an I.V. Sedation is being preformed, the amount of the treatment time @ \$50.00 per every ½ Hour will be non-refundable in the event that you do not show for your scheduled appointment.

A 24 Hour notice is required for all cancelled appointments.

20% of our usual fees will be added to each of the procedures even on PPO plans with insurance companies that we are currently contracted with and it will be solely the patient's responsibility to pay this additional fee. This amount is non-refundable with the insurance companies.

I, _____ understand the above statements and I agree to these financial stipulations.

X _____
(Signature of patient/Guardian/Parent)

Date: _____



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**Consent for services
Financial agreement**

All emergency dental services or any dental services without previous financial arrangements must be paid in cash at the time services are preformed.

I, agree to pay a cancellation fee of \$50.00 per every ½ hour of the scheduled appointment time that was set aside if I cancel my appointment with the office or service without giving a 24 hour notice. This also applies if I do not show for this appointment time and did not give the 24-hour notice.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and he/she is solely responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies, financial intuitions & other forms of services, and we will credit any such collections to the patients account.

However, the dental office cannot render services on the assumption that our charges will be paid by the insurance company.

A services charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimated listed for this dental care can only be extended for a period of six months from the date of the patients examination.

In consideration for the professional services rendered to me or for the guardianship for the patient/parental rights, or at my request, by the doctor, I agree therefore the reasonable value of said services to said doctor or his assignee at the time of said services are rendered, or within five days of billing, if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to me by me in writing within the time for payment thereof.

I further agree that the waiver of any breach of any time or condition hereunder shall not contain a waiver or any further term or condition and I agree to pay all cost and reasonable attorney fees and collection agency fees if a suit were instituted hereunder.

I grant my permission for you or an assignee, to telephone me at home, or at work, on my cell phone to discuss matters related to this form.

I HAVE READ THE ABOVE TERMS & CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONSENT.

X _____ Date: _____
(Signature of patient/Guardian/Parent)



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Signature on File

(Please initial next to each item)

_____ I authorize use of this form on all my insurance submissions.

_____ I authorize release of information to all my insurance companies

_____ I understand that I am responsible for my bill

_____ I authorize the doctor or his assignee to act as my agent in helping me obtain payment from my insurance companies.

_____ I authorize payment directly to Dr. Homanfar

_____ I permit a copy of my authorization to be used in place of the original.

_____ My signature also applies to the dependents listed below

Dependents:
