MERIDIEN
DENTAL

Name _____ I prefer to be called _____
Last First M.I. Mr./Mrs./Ms./Dr.

Male/Female Single/Married/Divorced/Widowed/Separated Social Security # _____

Birthdate ____/____/____Age _____ Drivers License #_____

Home Address_____
Street City State Zip

Home Phone (____) _____ E-Mail_____

Work Phone (____) _____ Ext_____ Best time to reach you at work _____. At home_____.

Employer _____

Employer's Address_____
Street City State Zip

Cell Phone (____)_____

How did you hear about us? Please circle one ZocDoc Google Facebook Yelp
Family or Friend Other: _____

Whom may we thank for referring you?_____

Responsible Party/Spouse/Parent/Guardian Information

Name: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security # _____

Work Phone (____)_____ Work Phone (____)_____ Home Phone (____)___

Employer _____ Occupation _____

Employer's Address _____
Street City State Zip

Insurance Information/Primary Insurance

Insurance Co. Name _____ Group or Policy#_____

Employer _____ Employee Name_____

Relation _____ Date of Birth_____/_____/_____ Social Security #____–___–_____

Continued on back

Emergency Contact:

Name: _____ Relationship to Patient: _____

Phone number: _____ E-Mail: _____

Dental History

Why have you come to the dentist today (chief complaint)? _____

Have you had x-rays taken in the past 1-5 years with this insurance? Yes No

Have you had a cleaning in the past 6 months with this insurance? Yes No

Do your gums bleed when you brush? Yes/No

Have you had periodontal disease/surgery? Yes/No

Medical History

Your current physical health is: Good / Fair / Poor

Physician's Name_____

Are you currently under the care of a physician? Yes/ No

Address_____

Please explain:_____

Phone (___)_____

_____

Do you smoke or use tobacco in any other form? Yes / No

Do you have a personal physician? Yes / No

Have you ever used Phen-Fen, Redux, Pondimin or Bisphosphonate? Yes / No

FOR WOMEN: Are you taking birth control pills: Yes / No **Are you pregnant**: Yes / No

Please mark "Yes" or "No" to indicate if you have any of the following:

Y N	Anemia	Y N	Headaches	Y N	Artificial Heart Valve
Y N	Angina	Y N	Hemophilia	Y N	Alcohol or Drug Dependency
Y N	Arthritis	Y N	Hepatitis	Y N	Pulmonary Disease
Y N	Asthma	Y N	Liver Disease	Y N	High Blood Pressure
Y N	Artificial Bones or Joints	Y N	HIV+/AIDS	Y N	Congenital Heart Defect
Y N	Blood Transfusions	Y N	Kidney Problems	Y N	Congestive Heart Failure
Y N	Cancer/Chemotherapy/Radiation	Y N	Lupus	Y N	Coronary Artery Disease
Y N	Cardiovascular Disease	Y N	Neurological Disorder	Y N	Damaged Heart Valve
Y N	Diabetes	Y N	Stroke	Y N	Heart Attack
Y N	Difficulty Breathing	Y N	Sexually Transmitted Disease	Y N	Heart Murmur
Y N	Emphysema	Y N	Sinus Trouble	Y N	Mitral Valve Prolapse
Y N	Epilepsy	Y N	Thyroid Problems	Y N	Pacemaker
Y N	Fainting Spells or Seizures	Y N	Tuberculosis (TB)	Y N	Rheumatic Fever
Y N	Gastrointestinal Disease	Y N	Ullcers	Y N	Rheumatic Heart Disease

Please list any medications you are currently taking: _____

Please list any other allergies: _____

Are you allergic to any of the following: Y N Codeine Y N Antibiotics Y N Latex
Y N Dental Anesthetics Y N Aspirin

Any other condition not listed that we should know about? _____

Treating Dentist Signature:_____ Date:_____

During your dental visits, when there is down time, would you prefer to:

A) Close your eyes and relax
B) Listen to some music
C) Watch a movie
D) Read a magazine

What is your favorite? band/artist: favorite TV show:

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment for services rendered, any deductible, and co-payment that my Insurance does not cover.

Signature_____ Date _____

Print Name _____

Peter H. Pham DDS
2825 Santa Monica Blvd., Suite 310 Santa Monica, CA 90404
P (310) 828-0700
F (888) 899-0270
www.MeridienDental.com

Written Financial Policy

Thank you for choosing Meridien Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Personal Checks (with valid forms of ID), Cashier Checks/ Bank Checks
- Cash or Debit Card
- Venmo (@meridiendental)
- If the patient would like to use a credit card (Visa, Mastercard, American Express, or Discover Card) as a form of payment, you are here by agreeing to a 3% service charge for all payments over $500.

Please note:

Meridien Dental requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your care.

Meridien Dental charges **$25** for returned checks.

For plans requiring multiple appointments such as orthodontic treatment, alternative payment arrangements may be provided.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees.

It is the patients' responsibility to notify our office of any dental insurance plan modifications or terminations.

It is also the patients' responsibility to inform Meridien Dental if you have used your insurance benefits for the year at any other dental office.

A fee of **$20** will apply to release patient x-rays. X-rays will be sent once the release form is signed and release fee has been paid.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent, or Guardian Signature Date

Patient Name (Please Print)

Peter H. Pham DDS
Sienna Palmer DDS
Cecilia Wang DMD

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement ☐ Other (Please Specify)

_____

_____

_____

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Appointment Cancellation Policy

To promote efficient access to our clinic, we require that any appointment that is no longer needed or is unable to be kept, must be cancelled at least **48 hours** in advance of the appointment. This allows for other patients to be scheduled into that appointment. Cancellations must be made during normal business hours on workdays at least two full business days before the scheduled appointment. Cancellations must be done over the phone by speaking directly to one of our dental professionals. Patients will not be charged if cancellation is made 48 business hours before their appointment.

In the event an appointment is missed or cancelled with less than **48 hours** notice, or no show, a $100 charge per hour scheduled will be added to the patients balance. After a third no-show or same day cancellation occurs, we reserve the right to terminate the doctor-patient relationship as well as another cancellation charge.

Additionally, if a patient is more than 20 minutes late for a scheduled appointment, we will consider this a missed appointment and the cancellation charge will be applied. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions or concerns.

We thank you for your patronage. I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient/Guardian Signature Date

_____

Patient Name (Print)