Oakland Smile Dental

Dr. Amiri and Associates

PATIENT INFORMATION

First Name: ___________________________MI:________ Last Name: _______________________DOB: ________________

Address: ___________________________________ City:___________________________ Zip: ________________________

SS#_______-____-________ Sex: M_____ F_____ Home Phone (   )_________________ Cell: (   )_________________

Driver's License #:___________________________ Email Address: ____

Employer: _________________________Position: _________________________How Long: __________________________

Marital Status: ____________________ Name of Spouse: ___________________Spouse Number: (   )________________

Emergency Contact: __________________________Relationship:_____________________ Phone: (   )________________

How did you hear about our office:____

Who was your previous dentist? ________________________ what did you like about him/her?_____________________

What did you dislike about him/her? ____

PERSON RESPONSIBLE FOR PAYMENT

(Disregard if same as above)

First Name: ___________________________MI:________ Last Name: _______________________DOB: ________________

Address: ___________________________________ City:___________________________ Zip: ________________________

SS#_______-____-________ Relationship to Patient: _________________ Driver's License #:_________________________

Occupation:_____________________ Length of Employment: _________ Employer: _________________________________

____.

DENTAL INSURANCE INFORMATION

	(Primary Carrier)	(Secondary Carrier)
Insured Name:	______________________________	______________________________
Insured DOB:	______________________________	______________________________
Insured SSN:	______________________________	______________________________
Relationship to Insured:	(Circle)	Relationship to Insured: (Circle)
	Self Child Spouse Parent Other	Self Child Spouse Parent Other
Insurance Company:	______________________________	______________________________
Insurance Co. Add.	______________________________	______________________________
Insurance Co. #:	______________________________	______________________________
Policy#:	______________________________	______________________________
Group#:	______________________________	______________________________

I agree to have my signature considered to be "on file" for purposes of insurance form processing. I also agree to be responsible for payment for any service or portion of service not covered by insurance. I authorize release of necessary information relating to the processing of dental insurance forms. In order for us to process your insurance forms more rapidly and to assist you in getting all the benefits to which you are entitled, please sign and date below.

I request that all dental benefits, if any or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistants and other medical personal. Failure to provide complete information may result in my receiving a bill of services._

X____ Date: ______________________________

Signature of Patient or Responsible Party

DENTAL HISTORY

Why have you come to the dentist today?____

Have you seen another dentist for your dental needs? Yes_____ No _____

Explain: ____

How would you describe the condition of your teeth and gums? Good ______ Fair _______ Poor _________

Are you currently in pain or discomfort with your teeth or gums? Yes______ No______

If yes, please explain:____

The date of your last dental visit: __________________ Reason for change in provider:___________________

____.

If you had a magic wand, and change anything you could about the appearance of your smile, what would you like to do?____.

If you could easily and safely whiten your teeth, would you be interested? Yes_____ No ______

How often do you brush your teeth? ______________________ Floss your teeth?________________________

Do your gums bleed when you brush? Yes______ No______ When Flossing? Yes_______ No _______

Are your teeth sensitive to: Hot? ______ Cold? _______ Sweet? _______

Have you ever experienced pain in your jaw joint? Yes ______ No ______

Do you grind your teeth? Yes _______ No ______

Have you ever had a night guard? Yes______ No ______ Do you still use it? Yes______ No ______

Have you ever been treated for TMJ symptoms? Yes ______ No ______

If yes, please explain: ____.

Is there anything else we need to know about your dental history? ___________________________________

____.

HEALTH HISTORY

First Name: ______________________ MI: ________ Last Name: ______________________

GENERAL HEALTH QUESTIONS

1. Have you had any serious illness, operations and or hospitalizations? ____

____.

2. Are you under a physician's care at this time? ____________________________

Please provide Name, address and phone # of physician: ____________________________

Do you have or did you ever have any of the following?

1. High blood pressure Yes ____ No ____
2. Angina or heart attack Yes ____ No ____
3. Chest pain or physical exertion Yes ____ No ____
4. Coronary artery blockage or Treatment (bypass, stent, etc) Yes ____ No ____
5. Heart valve problem or replacement Yes ____ No ____
6. Heart murmur Yes ____ No ____
7. Heart disease, problem or treatment Yes ____ No ____
8. Rheumatic Fever Yes ____ No ____
9. Past use of Fen-Phen Yes ____ No ____
10. Irregular heart beat or pacemaker Yes ____ No ____
11. Difficulty breathing when lying down Yes ____ No ____
12. Stroke Yes ____ No ____
13. Low blood pressure Yes ____ No ____

Respiratory Health

14. Asthma Yes ____ No ____
15. Emphysema or respiratory problems Yes ____ No ____
16. Chronic Sinus problem Yes ____ No ____
17. Tuberculosis or Persistent cough Yes ____ No ____

Endocrine/Blood/Immune Health

18. Diabetes Yes ____ No ____
19. Frequent thirst or frequent urination Yes ____ No ____
20. Thyroid Problems Yes ____ No ____
21. Abnormal bleeding, bruise easily Yes ____ No ____
22. Hemophilia Yes ____ No ____
23. Anemia/blood disease Yes ____ No ____
24. Cancer Yes ____ No ____
25. Radiation Therapy/Chemotherapy Yes ____ No ____
26. HIV infection/ AIDS Yes ____ No ____
27. Cold Score/Canker scores Yes ____ No ____
28. Organ Transplant Yes ____ No ____
29. Blood Transfusion Yes ____ No ____
30. Joint replacement Yes ____ No ____
31. Arthritis Yes ____ No ____
32. Osteoporosis Yes ____ No ____
33. Fainting spells or dizziness Yes ____ No ____
34. Seizures Yes ____ No ____
35. Numbness or muscle weakness Yes ____ No ____
36. Multiple sclerosis Yes ____ No ____
37. Mental Retardation Yes ____ No ____
38. Dementia/Alzheimer's disease Yes ____ No ____
39. Anxiety/Nervousness Yes ____ No ____
40. Mental Health treatment Yes ____ No ____

Gastro-Intestinal/Genito-Urinary Health

41. Hepatitis (A, B, C or Other) Yes ____ No ____
42. Liver Disease Yes ____ No ____
43. Kidney disease/dialysis Yes ____ No ____
44. Stomach Trouble/Ulcers Yes ____ No ____
45. Sexually transmitted disease Yes ____ No ____

Medication Allergies and Other Allergies

46. Penicillin or other antibiotics Yes ____ No ____
47. Sulfa Drugs Yes ____ No ____
48. Dental Anesthetic Yes ____ No ____
49. Aspirin Yes ____ No ____
50. Codeine/ Narcotics Yes ____ No ____
51. Iodine Yes ____ No ____
52. Latex Products Yes ____ No ____
53. Metals/ Nickels/ Jewelry Yes ____ No ____
54. Other: Yes ____ No ____

____.

Females Only

55. Are you pregnant? Yes ____ No ____
56. Are you nursing now? Yes ____ No ____
57. Do you take birth control pills? Yes ____ No ____

Medications

58. Are you taking any prescription medication, over the counter medications or herbal medicines? Yes ____ No ____

    ____.

59. Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelled , Didronel, Aredia, Zometa, Bonefos)?

    Yes ____ No ____

Social

60. Do you use tobacco? Yes ____ No ____ Quantity per Day ________
61. Do you use alcohol? Yes ____ No ____ Quantity per Day ________ Per Week ______
62. Do you use recreational Drugs? Yes ____ No ____ Quantity per Day ________
63. Do you have any other medical conditions not already listed above?

    Please list: ____.

I herby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the unsigned, consent to the performing of x-rays and examination.

Signature of Patient or Guardian ___________________________________ Date: ______________________

Dentist Signature ____________________________________ Date: ______________________

UPDATE:

Have there been any changes in your medical history, including any medications that you take since your last completed form? Yes ____ No ____

Signature of Patient or Guardian ___________________________________ Date: ______________________

Signature of Patient or Guardian ___________________________________ Date: ______________________

Signature of Patient or Guardian ___________________________________ Date: ______________________

PATIENT ACKNOWLEDGEMENT OF THENOTICE OF PRIVACY PRACTICE AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

First Name: ___________________________ MI:________ Last Name: _______________________

I, ____, acknowledge that I have either received a copy of

(Signature of Patient or Patient or Legal Guardian)

this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, ____, consent to the use and disclosure of my personal health information by your office for Treatment, Billing/Payment and Healthcare Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

General Dentistry

New and Recall patients must complete 1 thur 4 below, and 5 thru 13 as needed.

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

(Initials _______)

2. DRUGS, MEDICATION AND SEDATION

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous devices for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medication prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness or oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am current taking.

(Initials _______)

3. CHANGE IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials _______)

4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD/TMJ)

I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment where in the mouth is held in the open position. Although symptoms of the TMD associated with dental treatment are usually transitory in nature and well tolerated by most patient. I understand that should the need for treatment, the cost of which is my responsibility.

(Initials _______)

5. DENTAL PROPHYLAXIS (CLEANING)

I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the **absence of periodontal (gum) disease**.

(Initials _______)

6. FILLINGS

I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of newly placed filling.

(Initials _______)

7. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorized the Dentist to remove the following teeth ______________ and any other necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, exposed sinuses, loss of feeling in my teeth, lips, tongue and surrounding tissue (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials _______)

8. CROWNS, BRIDGES, VENEERS AND BONDING

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown,

bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials _______)

b. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge restorations.

(Initials _______)

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

(Initials _______)

9. DENTURES- COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initials _______)

10. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, ad that occasionally, canal material may extend through the root tip which does not necessarily effect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canal fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand the occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

(Initials _______)

11. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.). Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted immediately . I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

(Initials _______)

12. IMPLANTS

I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices, and infections may occur post operatively which may occur post operatively which may necessitate removal of the effected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissue of the oral cavity, and this numbness may be of a temporary or, rarely, permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointment and report as instructed by the treating dentist.

(Initials _______)

13. BLEACHING

Bleaching is a procedure done either in office (approximately 2 hours) or with take-home trays (several treatments over 24 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials _______)

14. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials _______)

15. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

(Initials _______)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other than the treating Dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature: _______________________________________ **Date: _____________________**

Doctor: ____ **Date: _____________________**

PLEASE READ CAREFULLY

Because we care so much about you and value you as our patient, we have comprised a New office policy regarding missed appointments and cancelled appointments.

This new policy has become a necessity and will affect all patients. It would be a disservice to you if we did not emphasize the importance of your own commitment to your dental care.

Your commitment to yourself and to us is to KEEP YOUR SCHEDULED APPOINTMENT. As always we will make every effort to accommodate your scheduling needs and keep our schedule "on time". In return, we ask that you help us by keeping your scheduled appointments and by notifying us 48 HOURS IN ADVANCE IF YOU ARE UNABLE TO DO SO.

Consider your appointment with Dr. Amiri and/or other Associate Dentist as your personal reservation. And, as with all reservations you make (such as airline or hotel), there must be a cancellation policy.

NEW CANCELLATION/MISSED RESERVED APPOINTMENT POLICY

1. **As a courtesy to you, we will make every effort to confirm your reserved appointment. But, please do not consider it not responsibility to do so. If our attempts are unsuccessful, it is your responsibility to keep your reserved appointment or contact us 48 hours in advance to change or cancel the reserved time.**
2. **All patients who fail to arrive for their reserved appointment or who cancel without 48 hours advance notice will be charged a $50.00 missed appointment fee. Please note that this missed appointment fee is NOT COVERED by any insurance plans and is your responsibility to pay. Fees shall be waived only for unforeseen circumstances at the Office Manager's discretion.**
3. **In recent months for the convenience of our patients Oakland Smile Dental is offered number of new specialties. Such as, Endodontic, Periodontist, Orthodontist; these specialist time has been reserved in advance and they are very much in demand. All patients who fail to arrive for their for their reserved appointment or who cancel without 72 hour adcance notice will be charged a $250.00 missed appointment fee. Fees shall be waived only for unforeseen circumstances at the Office Manager's discretion.**
4. **Furthermore due to the high demand for Saturday appointments and an increase in no shows or late cancelation; Oakland Smile Dental will follow new guidelines. Any patient that misses two Saturday appointment within a 6 month period will not be able to request Saturday appointments for a period of one year. All patients who fail to arrive for their reserved appointment or who cancel without 48 hours advance notice will be charged a $50.00 missed appointment fee.**
5. **If missed appointments become repeated, any future appointments will require a credit card number to be kept on file and used immediately for a missed appointment fee.**

In keeping with our high standards of dentistry, we prefer to accommodate all of our patients with longer, comfortable appointments. We know with busy and hectic life styles, this is what most patients prefer. In doing so, a one hour reserved appointment that is missed or cancelled late can upset an entire schedule.

We appreciate all of our patients and it is not our intent to offend anyone. With your compliance, we will be more albe to keep our schedule "on time", accommodate any emergencies and help patients on our waiting list. We thank you for your understanding in this matter.

Signature: ____ Date: ______________________