WELCOME

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Birthdate _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ 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 submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents 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 signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Phone (_____) _____ Work (_____) _____ Ext _____ Alt.Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reAlt.you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Tony Hashemian, DDS

CORONA DEL MAR DENTAL
CONSENT AND INFORMATION FORM

With any medical or dental treatment, there are benefits and risks. It is the belief of this office that you should be informed about the treatment and that you should give your consent before starting that treatment. The purpose of this form is to tell you about the risks that may occur with dental treatment and other treatment options.

RISKS OF GENERAL DENTAL PROCEDURES:

Including (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, anesthetics, and injections. These complications include pain, infection, swelling, bleeding, pulpitis (inflammation of the pulp), gingival recession, cyanotic or edematous tissue, metal allergy, pulpal exposure, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, permanent nerve damage, thrombophlebitis (inflammation of a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, fractured roots, “dry” (infected) sockets, and further treatment.

RISKS SPECIFIC TO ENDODONTIC THERAPY:

Root canal treatment is an attempt to retain a tooth which may otherwise require extraction. The risks associated with this procedure include instruments broken within the root, perforations of the crown or root of the tooth, over or under fills due to existing conditions, damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require additional treatment or referral to specialist.

OTHER TREATMENT CHOICES:

Our recommendations and advice are based upon experience and in a manner to minimize or avoid risks and success cannot be guaranteed. Treatment considerations include: root canals vs. extractions, fixed crowns and bridge vs. implants and partial (removable) dentures. The risk of no treatment includes (but not limited to): loss of bone support, teeth fractures, super-eruption of opposing teeth, pulpal infection, changes in teeth and jaw relationships, damage to adjacent teeth and restorations, and infection.

It has been explained to me that the course of the procedure(s) unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in the original treatment plan. I therefore authorize and request that Dr. Aguilera perform such procedures as are necessary and desirable in the exercise of professional judgment.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT.

Print Patient Name:_____

Patient/Guardian Signature:_____ Date:_____

PROTECTING YOUR CONFIDENTAL HEALTH INFORMATION IS IMPORTANT TO US

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Dear patient:

It is our desire to communicate to you that we are taking the new Federal (HIPAA-Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phones, faxes, copy machines, and charts. We believe this has been an importance exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws; we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment, and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED

To Provide Treatment

We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certifications, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us to make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interested to you or your family.

These communications are an important part of your philosophy of partnering with our patients to be sure they receive the best preventative and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friend and Caregivers
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participation in providing your care.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with y our written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

This new law is careful to describe that you have the following rights related to your health information.

Restrictions
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.
Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.
We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.
You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy information. Please let us know of your concerns or complaints in writing.

PATIENT ACKNOWLEDGMENT Patient Name:_____

Thank you very much for taking time to review how we are carefully using our health information. If you have any questions we want to hear form you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing. We look forward to seeing you again.

Patient Signature:_____ Date:_____

GENERAL DENTISTRY INFORMED CONSENT FORM

Patient Name_____

Please read and initial the items checked below. Then read and sign the section at the bottom.

□ **EXAMINATION AND X-RAYS:** I understand that radiographs may be required to complete the examination, diagnosis, and treatment plan. (Initial____)

□ **DRUGS, MEDICATION, AND SEDATION:** I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may have been given to me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. (Initial____)

□ **CHANGES IN TREATMENT PLAN:** I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on 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 or all changes and additions as necessary. (Initial____)

□ **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility. (Initial____)

□ **FILLINGS:** I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filling. (Initial____)

□ **REMOVAL OF TEETH (EXTRACTION):** Alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, ect.) and I authorize 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 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, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. (Initial____)

□ **CROWNS, BRIDGES, VENEERS, AND BONDING:** 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 crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in 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 modifications of daily cleaning procedures. (Initial____)

□ **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 my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not part of the initial denture fee. (Initial____)

□ **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). (Initial____)

□ **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. Alternative treatment plans have been explained to me, including no-surgical cleaning, antibiotic therapy, laser therapy, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleanings as directed, flossing a healthy diet, avoiding tobacco products and follow other recommendations. (Initial____)

I understand that I may receive a topical or local anesthetic for dental procedures. In rare instances patients may have a reaction to the anesthetic, which could require emergency medical attention. Complications resulting from the use of dental injections and anesthetics include and are not limited to: swelling, bleeding, infection, discomfort at site of injection, prolonged numbness and tingling (usually temporary, but can be permanent), jaw muscle cramps and spasms, jaw joint difficulty or pain radiating to head, neck, and ear, nausea and vomiting, allergic reaction, rapid or irregular heart beat, biting of the cheek, lip and tongue after treatment.

I have had full opportunity to discuss and ask questions regarding the dental treatment, and all my questions have been answered to my satisfaction.

Signature: _____ Date: _____

WARRANTY OF RESTORATIVE DENTAL TREATMENT

We are confident in our quality of work and support it with a warranty. We will repair, replace, or provide a refund for the restorative dental treatment rendered based on the following guidelines and exclusions for 18 months from the date of treatment. After the 18 months, you will be responsible for only the laboratory fee for up until three (3) years from the date of treatment. Failure to fulfill the following requirements will void the dental treatment warranty.

Terms and Conditions of our Dental Warranty:

1. You must remain an active patient after the procedure.
2. You must maintain a schedule of regular recall appointments, to include a minimum of an oral exam every 3-6 months, a cleaning every 3-6 months, bitewing x-rays every 12 months and a set of comprehensive x-rays every 5 years.
3. You must maintain a high standard of home dental care on all remaining natural teeth with a minimum of brushing and flossing 2 times per day.
4. We will replace the restorative dental work at no additional cost for either materials or labor if there is a failure in the fabrication within 18 months.
5. The warranty is null and void if the failure of restorative work is due to abuse or negligence due to any form of mistreatment of the piece. This includes but not limited to, biting into metal objects, chewing ice, self-adjustments, ect.
6. The warranty is null and void if the restorative work needs to be removed or is damaged due to a dental problem or repair with the supporting tooth/teeth including but not limited to root canals, recurrent decay, etc.
7. The warranty does not include any cost associated with routine maintenance required over the course of its working life.
8. If the doctor determines a night guard/ occlusal guard is necessary to maintain and protect your restorative work, the warranty will be null and void if you do not have one fabricated.

I certify that I have read and fully understand the warranty of our dental work

.

Patient Signature:_____ Date:_____