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:

Condition	Yes	No
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:

Condition			Condition			Condition		
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
Blood Disease	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Psychiatric Care	☐ 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 ______________

1538 E. Collins Ave
Orange, CA 92867
Office: 714-532-1139
Fax: 714-532-1233

Office Policy of Missed/Cancelation Appointment

We want to take the opportunity to inform of the importance of keeping your dental appointments. Our office values your time and our goal are to provide all of our patients with quality dental treatment in a timely manner. We make every attempt to confirm scheduled appointment in order to be respectful of other patient's dental needs. Please allow a minimum of 72 hours of any cancelations before your dental appointment to ensure that you will not be **charged $50**.

Each missed appointment is recorded in your dental records and you will receive a letter reminding you of your missed appointment policy.

Thank you for your consideration of this policy and we are glad that you have chosen our office as your healthcare provider.

____
Patient or Parent's Signature

____
Date

General Dental Consent Form

1. Examinations and X-rays

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. **Initials**_____

2. Treatment Plan

I understand the recommended treatment and my financial responsibility as explained to me. I understand that by signing this consent I am in no way obligated to any treatment. I also acknowledge 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. For example, root canal therapy following routine restorative procedures.
Initials _____

3. Drug and Medications

I understand that antibiotics, analgesics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock.
Initials _____

4. Temporomandibular Joint Dysfunction (TMD)

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

5. Extractions

Alternatives to removal of teeth have been explained to me (root canal therapy, crown and bridge procedures, periodontal therapy, etc.) I understand removing teeth does not always remove the infection, if present, and 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 (paresthesia) that can last for an indefinite period of time, or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.
Initials _____

6. Crown's, Bridges, Veneers

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 come off easily and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes (shape of, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation on within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge. I understand there will be additional charges for remakes due to my delaying permanent cementation. **Initials** _____

7. Endodontic Therapy

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses and defects in their manufacture can cause them to separate during use. I understand that 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 restore it.
Initials _____

8. Periodontal Disease

I understand that I have been diagnosed with a serious condition, causing gum and bone inflammation and/or loss and that the result could lead to the loss of teeth. Alternative treatments have been explained to me, including gum surgery, tooth extraction and/or replacement.

9. Fillings **Initials** _____

I understand that care must be exercised in chewing on filling teeth, especially during the first 24 hours to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decays I understand that significant sensitivity is a common after effect of newly placed fillings.
Initials _____

10. Partials and Dentures

I understand the wearing of partials/dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed at a later date. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of my partial/denture. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, additional charges could be incurred.
Initials _____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot property guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized.

____
Print Patient's Name

____
Patient's Signature Date

____
Clinical Staff Date

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: ______________________________

Printed Name-Patient or Responsible Party

____

Patient Signature or Responsible Party Date

____

Relationship to patient (if other than patient)

Witness:

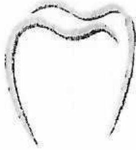
____

Printed Name-Practice Representative

______________________ ____/____/________

Signature Date

Samira Seini, D.D.S
1538 E. Collins Avenue
Orange, CA 92867



Patient Acknowledgement of Receipt of Dental Materials Fact Sheet and Notice of privacy Practices

As of January 1, 2002, the Dental Board of California requires that we distribute to our patients a copy of The Dental Material Fact Sheets.

In addition, The Health Insurance Portability and Accountability Act (HIPPA) requires, effective April 14, 2003, that patients be given a copy of our Notice of Privacy Practice.

Please print and sign your name below.

I, ______________________________, acknowledge that I have received from this office:

1. A copy of the Dental Materials Fact Sheet
2. The Notice of Privacy Practice

______________________________ ______________

Patient's or Parent's or Guardian's signature Date

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

____

Patient Name

____

Relationship of signatory

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:__________