Aesthetic Dentistry

Vahid Varasteh, D.M.D.

Patient Intake Information

Patient Information

Name: _____ Today's Date: _____

DOB: _____ SS# _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ □ Home □ Cell Alt Phone: _____

Email: _____ Primary Language: □ English □ Spanish □ Other: _____

Emergency Contact: _____

Name Relationship Phone

What is the reason for your visit / Chief Complaints? _____

_____

How did you hear about us? _____

Primary Dental Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

Secondary Dental Insurance Information

Insurance Company: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Patient Relationship to Subscriber: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named Insurance Company and assign directly to Aesthetic Dentistry all insurance benefits, if any, 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 medical facility may use my healthcare 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 benefits payable to related services. This consent will stay in effect as long as I am a patient with the above-named medical facility.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative

Name of Patient, Parent, Guardian, or Personal Representative (Print)

_____ _____

Date

Relationship to Patient

Preferred Pharmacy Information

Pharmacy Name:_____ Pharmacy Phone:_____

Pharmacy Street Address: _____

Dental History and Oral Health

Date of last dental visit:_____ Date of last dental X-ray: _____

Have you ever been treated for periodontal disease? □ Yes □ No Have you ever had Novocaine / other local anesthetic? □ Yes □ No

One a scale of 1 (not happy) to 10 (very happy), how happy are you with your smile? _____

Please check any dental conditions that apply to you:

□ Pain in Jaw (TMJ) □ Teeth Grinding / Clenching □ Use Tobacco Products □ Swollen / Bleeding Gums

□ Mouth Sores □ Broken / Loose Teeth □ Sensitive Teeth □ Difficulty Chewing / Swallowing

□ Crooked / Spaced Teeth □ Unhappy w/Tooth Color/Appearance

Are you in pain? □ Yes □ No Do you experience any fears or anxieties related to dental treatment? □ Yes □ No

If Yes, please explain: _____

Do you need to be pre-medicated before dental treatment? □ Yes □ No

Medical History

Primary Care Provider (Name and Phone): _____

Date of last physical:_____ Are you taking birth control? □ Yes □ No □ Not Applicable

Are you currently pregnant or nursing? □ Yes □ No □ Not Applicable Estimated due date, if applicable: _____

Please list any prior hospitalizations or surgeries, including dates: _____

_____

Is the patient currently using alcohol or drugs (including tobacco)? □ Yes □ No

If yes, Type:_____ Frequency:_____ Amount: _____

Do you require antibiotics prior to dental procedures? □ Yes □ No

Are you currently taking or have you taken any steroid / cortisone therapy in the last 2 years? □ Yes □ No

Are you currently taking or have you ever taken Oral Bisphosphonates (e.g. FOSAMAX, BONIVA) or IV Bisphosphonates? (e.g. ZOMETA, AREDIA)? □ Yes □ No If yes, for how long?_____

Are you allergic or have you ever had an adverse reaction to any of the following?

□ None □ Amoxicillin □ Aspirin □ Codeine □ Epinephrine □ Latex □ Ibuprofen
□ Metals □ Penicillin □ Sulfa □ Tetracycline □ Erythromycin □ Z-pack

Please specify any other known allergies: _____

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

Please list any current prescribed medications or supplements you are taking, or have used over a long period of time (e.g. prescription, dosage, dates):

Prescription / Supplement Name	Dosage/ Frequency	Dates

Conditions *(Please check all that apply)*

- ☐ None
- ☐ Alcoholism
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
  Type & Age: _____
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
  Type:_____
- ☐ Chemotherapy
- ☐ Coumadin Therapy
- ☐ Dementia
- ☐ Diabetes
  Type: _____
- ☐ Drug Addiction
- ☐ Epilespy
- ☐ Excessive Bleeding
- ☐ Fainting / Dizziness
- ☐ Hearing Impairment / Loss
- ☐ Heart Murmur
- ☐ Heart Surgery
  Type: _____
- ☐ Heart Trouble
  Type: _____
- ☐ Hepatitis
  Type: _____
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease / COPD
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Mobility Impairment
- ☐ NON-DENTAL Implants
  Type: _____
- ☐ Organ Transplants
  Type: _____
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Radiosurgery
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Visual Impairment
- ☐ Other Disease / Illness
  Type: _____

_____

_____ _____

Patient Signature **Date**

_____ _____

Doctor's Signature **Date**

Informed Consent to Treatment

Drugs and Medication
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).
(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 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 once they've been discovered and discussed. (Initial:_____)

X-Rays
I understand x-rays are necessary for proper diagnosis and treatment. (Initial:_____)

Restoratives
I understand that a more expensive restorative may be required due to additional decay than what could be seen by the x-ray and that significant sensitivity is a common aftereffect of a newly placed restorative. (Initial:_____)

Local Anesthetic
Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection. Risks include but are not limited to.' It is normal for the numbness to take time to wear off after treatment, usually two to three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting, and cheek, tongue, or lip biting can occur. Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during dental treatment. (Initial:_____)

I understand that dentistry is not an exact science, and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction. I consent to the proposed treatment.
(Initial:_____)

General Consent to Treatment

1. I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.
2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.
3. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.
4. I certify that if I and/or my dependents have insurance coverage, I assign directly to the dentist all insurance benefits 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.
5. I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner, and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

Patient Name (Print)

Patient or Parent | Guardian Signature

Date

Aesthetic Dentistry

Vahid Varasteh, D.M.D.

HIPPA POLICIES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMAION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OFYOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights conferring your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 08/01/2008, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain,including health information we created or received before we made the changes. Before we make a significant change inour privacy practice, we will change this notice and make the new notice available upon request. You may request a copyof our notice at any time. For more information about our privacy practices, or for additional copies of this notice, pleasecontact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

Treatment: *We may use or disclose your health information to a physician or other healthcare provider providingtreatment to you.*

Payment: *We may use or disclose your health information electronically or by mail to obtain payment from health plansand insures for the care that we provide to you.*

Healthcare Operations: *We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualificationsof healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.*

Your Authorization: *In addition to our use of your health information for treatment, payment or healthcare operations,you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.*

Persons Involved In Care: *We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacityor emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your bestinterest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.*

(USES AND DISCLOSURES OF HEALTH INFORMATION CONTINUED)

Marketing Health-Related Services: *We will* ***not*** *use your health information for marketing communications without yourwritten authorization.*

Required by Law: *We may use or disclose your health information if, by law, we are required to do so.*

Appointment Reminders: *We may use or disclose your health information to provide you with appointment reminders(such as phone calls, voicemail messages, text, email, postcards, or letters).*

Electronic Transfers: *We may use or disclose your health information electronically if in relations to obtain payment,referrals for another health care provider or unless otherwise stated with your permission.*

ACKNOWLEDGEMENT FORM

I have received the "**Notice of Privacy Practices**" and have been provided an opportunity to review it.

Patient Name (Print)	Patient Date of Birth
Parent | Guardian Name if Patient is a Minor (Print)	Relationship to Patient
Signature	Date

Personal Health Information Release Form
(HIPAA Release Form)

[ ] I authorize the release of any and all information including the diagnosis, financial and dental records;examination rendered to me and claims information. This information may be released to:

[ ] Name _____D.O.B._____Phone_____

[ ] Name_____D.O.B._____Phone_____

[ ] Information is **not** to be released to anyone.

Signature_____ Date_____

This *Release of Information* will remain in effect until terminated by me in writing.