Agoura Hills DENTAL DESIGNS

28632 ROADSIDE DR. SUITE 270
AGOURA HILLS , CA 91301

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

DATE _____

PATIENT INFORMATION

NAME _____ SSN _____
LAST NAME FIRST NAME INITIAL

HOME PHONE _____ CELL PHONE _____ EMAIL _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX ❑ M ❑ F AGE _____ BIRTHDATE _____ ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ SEPARATED ❑ DIVORCED

PATIENT EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? _____ PHONE _____

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____
LAST NAME FIRST NAME INITIAL

RELATION TO PATIENT _____ BIRTHDATE _____ SSN _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

PERSON RESPONSIBLE EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

INSURANCE COMPANY _____

CONTACT# _____ GROUP# _____ SUBSCRIBER# _____

NAMES OF OTHER DEPENDENTS COVERED UNDER THIS PLAN _____

ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ❑ YES ❑ NO

SUBSCRIBER NAME _____ RELATION TO PATIENT _____ BIRTHDATE _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____ PHONE _____

CITY _____ STATE _____ ZIP _____

PERSON RESPONSIBLE EMPLOYED BY _____ PHONE _____

INSURANCE COMPANY _____ SSN _____

CONTACT# _____ GROUP# _____ SUBSCRIBER# _____

NAMES OF OTHER DEPENDENTS COVERED UNDER THIS PLAN _____

PLEASE COMPLETE BOTH SIDES

HEALTH HISTORY

I. CHECK APPROPRIATE ANSWERS (LEAVE BLANK IF YOU DO NOT UNDERSTAND THE QUESTION)

YES NO

❑ ❑ 1. IS YOUR GENERAL HEALTH GOOD?
❑ ❑ 2. HAS THERE BEEN A CHANGE IN YOUR HEALTH WITHIN THE LAST YEAR?
❑ ❑ 3. HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS IN THE LAST THREE YEARS?

PLEASE EXPLAIN_____

❑ ❑ 4. ARE YOU BEING TREATED BY A PHYSICIAN NOW? PLEASE EXPLAIN

DATE OF LAST MEDICAL EXAM_____/_____/_____ DATE OF LAST DENTAL APPT_____/_____/_____

❑ ❑ 5. NAME OF MEDICAL DOCTOR _____PHONE NUMBER (_____)_____

❑ ❑ 6. HAVE YOU HAD PROBLEMS WITH PRIOR DENTAL TREATMENT?

PLEASE EXPLAIN_____

❑ ❑ 7. ARE YOU IN PAIN NOW?

II. HAVE YOU EXPERIENCED:

YES NO

❑ ❑ 8. CHEST PAIN (ANGINA)?
❑ ❑ 9. SHORTNESS OF BREATH?
❑ ❑ 10. RECENT WEIGHT LOSS, FEVER, NIGHT SWEATS?
❑ ❑ 11. PERSISTENT COUGH, COUGHING UP BLOOD?
❑ ❑ 12. BLEEDING PROBLEMS, BRUISING EASILY?
❑ ❑ 13. SINUS PROBLEMS?
❑ ❑ 14. DIARRHEA, CONSTIPATION, BLOOD IN STOOLS?
❑ ❑ 15. FREQUENT VOMITING, NAUSEA?
❑ ❑ 16. DIFFICULTY URINATING, BLOOD IN URINE?

YES NO

❑ ❑ 17. DIZZINESS, RINGING IN THE EARS?
❑ ❑ 18. HEADACHES, FAINTING SPELLS?
❑ ❑ 19. BLURRED VISION?
❑ ❑ 20. SEIZURES?
❑ ❑ 21. EXCESSIVE THIRST, FREQUENT URINATION?
❑ ❑ 22. DRY MOUTH?
❑ ❑ 23. JAUNDICE
❑ ❑ 24. JOINT PAIN, STIFFNESS?

III. DO YOU HAVE OR HAVE YOU HAD:

YES NO

❑ ❑ 25. HEART ATTACK, HEART DISEASE?
❑ ❑ 26. HEART MURMURS?
❑ ❑ 27. RHEUMATIC FEVER?
❑ ❑ 28. STROKE, HARDENING OF ARTERIES?
❑ ❑ 29. HIGH BLOOD PRESSURE?
❑ ❑ 30. TB, EMPHYSEMA, ASTHMA, OTHER LUNG DISEASE?
❑ ❑ 31. HEPATITIS, OTHER LIVER DISEASE?
❑ ❑ 32. STOMACH PROBLEMS, ULCERS?
❑ ❑ 33. ALLERGIES TO: DRUGS, FOOD, MEDICATIONS, LATEX?
❑ ❑ 34. FAMILY HISTORY OF DIABETES, HEART PROBLEMS, TUMORS?

YES NO

❑ ❑ 35. AIDS, ARC OR HIV POSITIVE?
❑ ❑ 36. CANCER, TUMORS?
❑ ❑ 37. ARTHRITIS, RHEUMATISM?
❑ ❑ 38. EYE DISEASE, SKIN DISEASE?
❑ ❑ 39. ANEMIA?
❑ ❑ 40. VD (SYPHILIS OR GONORRHEA)?
❑ ❑ 41. HERPES?
❑ ❑ 42. KIDNEY, BLADDER DISEASE?
❑ ❑ 43. THYROID, ADRENAL DISEASE?
❑ ❑ 44. DIABETES?

IV. DO YOU HAVE OR HAVE YOU HAD:

YES NO

❑ ❑ 45. PSYCHIATRIC CARE?
❑ ❑ 46. RADIATION TREATMENTS?
❑ ❑ 47. CHEMOTHERAPY?
❑ ❑ 48. PROSTHETIC HEART VALVE?
❑ ❑ 49. ARTIFICIAL JOINT?
❑ ❑ 50. HOSPITALIZATION?
❑ ❑ 51. BLOOD TRANSFUSIONS?
❑ ❑ 52. SURGERIES?
❑ ❑ 53. PACEMAKER?
❑ ❑ 54. PHEN-PHEN MEDICATION?

V. ARE YOU TAKING?

YES NO

❑ ❑ 55. RECREATIONAL DRUGS?
❑ ❑ 56. TOBACCO IN ANY FORM?
❑ ❑ 57. ALCOHOL?
❑ ❑ 58. DRUG, MEDICINES, (INCLUDING ASPIRIN)?

PLEASE LIST_____

VI. WOMEN ONLY:

❑ ❑ 59. ARE YOU OR COULD YOU BE PREGNANT OR NURSING?
❑ ❑ 60. TAKING BIRTH CONTROL PILLS?

VII. ALL PATIENTS

YES NO

❑ ❑ 61. DO YOU GRIND YOUR TEETH?
❑ ❑ 62. DO YOUR JAWS POP, LOCK OR HURT?
❑ ❑ 63. HAVE YOU EVER HAD GUM TREATMENT (PERIODONTAL DISEASE)?

HOW LONG SINCE LAST DENTAL X-RAYS? _____

HOW LONG SINCE LAST DENTAL TREATMENT?_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED EVERY QUESTION COMPLETELY AND ACCURATELY. I WILL INFORM MY DENTIST OF ANY CHANGE IN MY HEALTH AND/OR MEDICATION. I AUTHORIZE MY INSURANCE COMPANY TO PAY THE DENTIST OR DENTAL GROUP ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I AUTHORIZE THE DENTIST TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

PATIENT'S SIGNATURE _____ DATE_____

DENTIST'S SIGNATURE _____ DATE_____

DATE	BY	CHANGES IN HEALTH YES	CHANGES IN HEALTH NO	MEDICATIONS YES	MEDICATIONS NO	LAST PHYSICAL	SIGNATURE/COMMENTS

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(AFFIX PATIENT LABEL HERE)

PATIENT CONSENT TO TREATMENT

IN READING AND SIGNING THIS FORM IT IS UNDERSTOOD THAT ENGLISH IS THE LANGUAGE THAT I UNDERSTAND AND USE TO COMMUNICATE. _____ (Initials)

[X] 1. DRUGS, MEDICATIONS, AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs. or until fully recovered from their effects (this includes a period of at least twenty four (24) hours after my release from surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia and/or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloryl hydrate, "Zanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction or airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway. _____ (Initials)

[ ] 2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing), proper diet which includes fruits and vegetables and regular recall visits.

PERIODONTICS - I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed because it all depends on how I take care of my oral hygiene to prevent any plaque formation.

Occasionally treated teeth may require extraction. I also understand that I need every three (3) month recall visits. _____ (Initials)

[ ] 3. REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time.

Potential risks of surgery/extraction include but are not limited to, the following:

A. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery).
B. Injury to adjacent teeth, caps, or fillings (requiring the recementation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area.
C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery).
D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications, and are kept on a close observation for any symptoms which indicate the necessity of surgery to remove the fragments.
E. Possible bone fracture which may require wiring or surgical treatment.
F. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.
G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side; this may persist for several weeks, months, or, in remote instances, permanently.
H. I understand sometimes asymptomatic decidious tooth/teeth (Baby tooth) are extracted prematurely to accommodate the eruption of permanent tooth/teeth even through they are not loose. _____ (Initials)

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever (s)he may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility. _____ (Initials)

[ ] 4. FILLINGS:

I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines. The advantages and disadvantages of alternate materials have been explained to me. _____ (Initials)

[ ] 5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY):

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth, unless I belong to any Managed Care, Medi-Cal or Insurance Plan with exclusions or limitations then it will be my responsibility to pay for the crown.

I understand that treatment risks can include, but are not limited to the following:

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
C. Infection.
D. Restricted jaw opening
E. Breakage of root canal instruments during treatment. which may in the judgment of the doctor be left in the treated root canal or bone as part of the filling material; or it may require surgery for removal, and I may need to see a specialist for such surgery at my own expense.
F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
G. Risk of temporary or permanent numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized, I expose myself to infection and/or tooth lose.

If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted. _____ (Initials)

[ ] 6. CROWN AND BRIDGE (CAPS):

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy.

I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

I understand that 1 need to use floss threaders, water pick to keep crown and bridge area clean of any plaque formation. _____ (Initials)

[ ] 7. DENTURES - COMPLETE OR PARTIAL:

The problems of wearing dentures has been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori[bone) removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

I have also been explained and offered the option of Implants in place of full dentures and partials. (Initials)

[ ] 8. PEDODONTICS (CHILD DENTISTRY):

I understand that the following procedures are routinely used on my child and are well accepted procedures in the dental profession.

A. POSITIVE REINFORCEMENT - Rewarding the child who portrays desirable behavior, by use of compliments, praise a pat or hug, and/or token objects or toys.
B. VOICE CONTROL - The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. PHYSICAL RESTRAINT - Restraining the child's disruptive movements by holding down their hands, upper body, head, and or legs by use of the dentist's or assistant's hand or arm, or by use of a special device (referred to as a "papoose board").
D. NITROUS OXIDE AND/OR ORAL SEDATION - If I choose to have Nitrous oxide and oxygen (mix) for sedation, it is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the parent or guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure and observe their behavior throughout the day.
E. I am also signing a separate "Informed Consent" to give my consent for uncooperative children.

I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction. _____ (Initials)

[ ] 9. VISITS:

I was given the option of receiving quadrant (one side at a time) dentistry hut due to time restraints and/or transportation problems. I have requested the doctor to complete as many procedures as possible. _____ (Initials)

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

Signature: _____ Relationship: _____ Date: _____
Patient or Legal Representative

Doctor: _____ Witness: _____

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OFFICE POLICY
Financial Policy

To our Valued Patients:

In today's world of rising prices, we are trying to keep our fees at the minimum by implementing clear and exact payment policies. This helps reduce our overhead allowing us to pass the savings on to our patients.

Here is how this policy works: We will continue to file insurance claims on your behalf as always. For your insurance co-payments, or if you are uninsured, we offer the following payment policies:

1. We offer a 5% Professional Credit on fees over $500 that are paid in full before the day of treatment. (Payment in Advance)
2. Patients with Insurance are required to pay their Deductible and Estimated Portion (Co-Pay) in advance, before treatment is given.
3. The patient, or guardian of a patient if the patient is a minor, is fully responsible for the total cost of treatment. This means that you must pay any amounts not covered by your insurance carrier.
4. Regarding Insurance:
   a. Our relationship is with you, the patient; not the Insurance Carrier
   b. You own the relationship with your Insurance Carrier. You are their customer.
   c. We do handle the Insurance claim paperwork for you as a courtesy BUT if we do not receive payment from your Insurance Carrier in 45 days, payment becomes your responsibility.
5. We have made arrangements with a health care financing program to provide our patients extended payment plans at low interest rates, including a 12 month interest-free program. Applications are available from our front office staff.
6. Our goal regarding service is "No Patients Waiting". We are making every effort to stay on schedule. Please help by being prompt for your appointment.
7. Your appointment time is reserved for you. We reserve that right to charge 50% of the treatment fee or $50 for missed appointment. (To avoid this please call and cancel or change appointments 24 hours in advance.)

I have read the above policies and agree to abide by them.

Signed: _____ Date: _____

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www.AgouraHillsDentalDesigns.com

APPOINTMENT POLICY

We attempt to make confirmation calls, send texts, as well as emails and voice mail messages at least 48 hours in advance of your scheduled appointment as a courtesy. Therefore, we ask that our patients kindly give us a 48-hour notice if there is a need to cancel or reschedule an appointment. A one-time consideration will be made for failure to give notice. Any cancellations or no shows after that will be charged a $75.00 fee

Thank you for your understanding of this matter, as we strive to provide the best quality care for our patients.

Sincerely

Dr. Kiumars Rahimi and Staff

I have read the above appointment policy, and I understand that I will be charged if I fail to show up for my scheduled appointment.

Signed: _____ Date: _____

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:_____

You have the right to refuse to sign this Acknowledgement.

I, _____ , have received a copy of this office's **NOTICE OF PRIVACY PRACTICES** as required by federal law.

_____

Print Patient's Name

_____

Patient's Signature

FOR OFFICE USE ONLY

On the date above we made a "good faith effort" to obtain written acknowledgement of receipt pf our **NOTICE OF PRIVACY PRACTICES.** We were unable to obtain acknowledgment for the following reason:

❑ Patient refused to sign

❑ Other _____
(Possible Reasons: Language Difficulty, Communication Barriers, Dental Emergency)

_____ _____

(Printed Name) (Signature of employee attempting to gain acknowledgement)