## PATIENT INFORMATION

*(This information is necessary for our files and will be considered* ***CONFIDENTIAL****)*

Date _____

Patient's Name _____ (LAST / FIRST / INITIAL) Age _____ Patient's Birthday _____ ❑ Male ❑ Female

If patient is a minor give name of parent or legal guardian _____ Relationship _____

Residence Address _____ (STREET / CITY / ZIP) For how long? _____ ❑ Own ❑ Rent

Patient is ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Minor

Cell ( )

Email Address _____ Social Security No. _____ Res. Phone ( ) _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET / CITY / ZIP) Bus. Phone ( ) _____

Spouse's Name _____ Driver's License No. _____ Soc. Sec. No. _____

Employed by _____ How long? _____ Occupation _____

Business Address _____ (STREET / CITY / ZIP) Bus. Phone ( ) _____

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ (STREET / CITY / ZIP) Res. Phone ( ) _____

❑ I have no physician

Name of Physician _____ (ADDRESS / CITY) Telephone ( ) _____

Former Dentist _____ (ADDRESS / CITY) Telephone ( ) _____

Is this office visit for Emergency Dental Care? ❑ Yes ❑ No If yes, explain _____

## FINANCIAL INFORMATION

Person responsible for this account _____ Relationship _____

Address _____ Telephone ( ) _____

Name of insurance company (primary insurance) _____

Insured person's name _____ Relationship _____ Soc. Sec. No. _____

Name of group dental plan _____

## TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services or any dental service performed without prior financial arrangements must be paid in cash at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff. I agree to pay, therefore, the reasonable value of said Doctor or his assignee at the time said services are rendered. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

I grant my permission to you or your assigns to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

Signed _____ Date _____

REV. 10/01

*PLEASE COMPLETE BOTH SIDES*

**PATIENT NAME** _____ _____ DATE _____

**Social Security Number** _____

Primary reason for this dental appointment ☐ Examination ☐ Emergency ☐ Consultation ☐ Dental Pain

## DENTAL HISTORY

Please Circle

Do you have a specific dental problem? If yes, describe _____ Yes No

How long have you experienced this problem? _____

Are you having pain at this time? If yes, describe _____ Yes No

Have you been advised that you have active decay or gum disease? By who? _____ Yes No

How often do you brush your teeth? _____

Do you floss? How often? _____ Yes No

Do your gums ever bleed? If yes, explain. _____ Yes No

Do you like your smile? Why? _____ Yes No

Does food catch between teeth? _____ Yes No

Do you have any loose teeth? _____ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? _____ Yes No

Do you brux or grind your teeth? _____ Yes No

Have you ever had any bad experiences in a dental office? If yes, where? _____ Yes No

What is the name of your previous dentist? _____

How often do you visit a dentist? _____

When was your last dental visit? _____

## MEDICAL HISTORY

Are you currently under a physician's care? Why? _____ Name of Physician _____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had an injury to your head or neck? If yes, where? _____ Yes No

If yes, was treatment received? Where? _____ Yes No

If yes, please explain. _____ Yes No

Are you taking any medications, pills or drugs? What? _____ Yes No

Are you on a special diet? If yes, discuss _____ Yes No

Are you allergic to any medications or substance? Please check box below. _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

*Women:* Please check ☐ Pregnant (or trying to get pregnant) ☐ Nursing ☐ Taking Oral Contraceptives

Discuss _____

Do you now have or have you ever had any of the following? Please appropriate boxes.
If yes to any of the checked conditions, please call prior to your appointments. Premedication may be required.

| | Yes | No | | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart Trouble/Disease | [ ] | [ ] | Bruise Easily | [ ] | [ ] | Emphysema | [ ] | [ ] | Yellow Jaundice | [ ] | [ ] | Cold Sores | [ ] | [ ] |
| Heart Murmur | [ ] | [ ] | Anemia | [ ] | [ ] | Tuberculosis | [ ] | [ ] | Kidney Problems | [ ] | [ ] | Fever Blisters | [ ] | [ ] |
| Irregular Heart Beat | [ ] | [ ] | Excessive Bleeding | [ ] | [ ] | Cancer | [ ] | [ ] | Renal Dialysis | [ ] | [ ] | Herpes | [ ] | [ ] |
| Angina/Chest Pain | [ ] | [ ] | Sickle Cell Disease | [ ] | [ ] | X-ray treatment (radiation) | [ ] | [ ] | Thyroid Disease | [ ] | [ ] | Stroke | [ ] | [ ] |
| Heart Attack/Failure | [ ] | [ ] | Hemophilia | [ ] | [ ] | Chemotherapy | [ ] | [ ] | Parathyroid Disease | [ ] | [ ] | Convulsions | [ ] | [ ] |
| Congenital Heart Disorder | [ ] | [ ] | Leukemia | [ ] | [ ] | Stomach/Intestinal Disease | [ ] | [ ] | Arthritis/Gout | [ ] | [ ] | Epilepsy or Seizures | [ ] | [ ] |
| Mitral Valve Prolapse | [ ] | [ ] | Recent Blood Transfusion | [ ] | [ ] | Ulcers | [ ] | [ ] | Rheumatism | [ ] | [ ] | Fainting or Dizziness | [ ] | [ ] |
| Scarlet Fever | [ ] | [ ] | Swelling of Limbs | [ ] | [ ] | Recent Weight Loss | [ ] | [ ] | Pain in jaw joints | [ ] | [ ] | Glaucoma | [ ] | [ ] |
| Artificial Heart Valve | [ ] | [ ] | Breathing Problem | [ ] | [ ] | Diabetes | [ ] | [ ] | Artificial Joint | [ ] | [ ] | Nervousness | [ ] | [ ] |
| Heart Pace Maker | [ ] | [ ] | Shortness of Breath | [ ] | [ ] | Excessive Thirst | [ ] | [ ] | Venereal Disease | [ ] | [ ] | Psychiatric Care | [ ] | [ ] |
| Heart Surgery | [ ] | [ ] | Frequent Cough | [ ] | [ ] | Hypoglycemia | [ ] | [ ] | AIDS | [ ] | [ ] | Alzheimer's Disease | [ ] | [ ] |
| High Blood Pressure | [ ] | [ ] | Hay Fever | [ ] | [ ] | Liver Disease | [ ] | [ ] | HIV Positive | [ ] | [ ] | Allergies (Medications) | [ ] | [ ] |
| Low Blood Pressure | [ ] | [ ] | Sinus Trouble | [ ] | [ ] | Hepatitis A (infectious) | [ ] | [ ] | Genital Herpes | [ ] | [ ] | Allergies (pollen/dust) | [ ] | [ ] |
| Blood Disease | [ ] | [ ] | Asthma | [ ] | [ ] | Hepatitis B / C | [ ] | [ ] | Drug Addiction | [ ] | [ ] | Hives or Rash | [ ] | [ ] |
| Phen-Fen | [ ] | [ ] | | | | | | | | | | | | |

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist about any problem? _____ Yes No

To the best of my knowledge, I certify under penalty of perjury, that the above information is true and correct. If I have any changes in my health _____
or if my medications change, I understand that it is my responsibility to inform the dentist and staff immediately.

_____ Date _____

PATIENT SIGNATURE (PARENT OR GURDIAN)

Reviewed by Doctor _____ Date _____ BF _____

History Reviewed _____ Significant Findings: _____

## MEDICAL UPDATES

| Date | Exceptions | | Patient's Signature | BP-baseline | Reviewed by | |
|---|---|---|---|---|---|---|
| _____ | _____ | None [ ] | _____ | _____ | _____ | Dr. _____ |
| _____ | _____ | None [ ] | _____ | _____ | _____ | Dr. _____ |
| _____ | _____ | None [ ] | _____ | _____ | _____ | Dr. _____ |
| _____ | _____ | None [ ] | _____ | _____ | _____ | Dr. _____ |
| _____ | _____ | None [ ] | _____ | _____ | _____ | Dr. _____ |
| _____ | _____ | None [ ] | _____ | _____ | _____ | Dr. _____ |
| _____ | _____ | None [ ] | _____ | _____ | _____ | Dr. _____ |

REV. 1/01

# Protecting Your Confidential Health Information is Important to Us

## Abuse or Neglect
We will notify government authorities if we believe a patient is victim of abuse 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 disclosure 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 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, Friends and Caregivers
We may share your health information with those you tell us will be helping you with 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 participating in providing your care.

## Authorization to Use or Disclose Health Information
Other than as stated above or where Federal, State or Local Law requires us we will not disclose your health information other than with your 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.

## Patient Acknowledgement
Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions we want to hear from you , if not we would appreciate very much your acknowledging your receipt of our policy by reading and signing this sheet. We look forward to seeing you again soon!

Patient Name:(PRINT)_____

Patient Signature:_____

## 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 restrictions 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 member 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 correct 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 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 14th 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your requests to no more than six 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 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 right to express complaints to us or the Secretary of Health and Human Services if you believe your rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

# Affordable Dentistry

**Dr. Sonny Aryan, DDS**

**4501 Mission Bay Drive Suite 2E**

**San Diego, CA 92109**

**(858) 270-6626**


## Missed Appointment Policy

This form is to notify that patient will be charged $50.00 for any appointments missed, unless this office is notified 48 hours in advance of the time of the appointment. If your appointment is on Monday, then the notice of cancellation must be received before 5:00 PM on the prior Friday.

Patient name_____

Patient Signature _____ Date _____

## Fee for Service Policy

I understand that my estimated share of cost is due and payable the day of treatment. Services that are not covered, or considered optional by my dental plan will be my full responsibility. Any change in my treatment plan either by my choice or by necessity may change the fees originally quoted. It will be my responsibility to pay for any treatment that my insurance refuses to pay. Any unpaid balance will be subject to a 15% interest fee monthly until paid in full.

I have read, and fully understand that all treatment must be paid on the date of service unless there is a specific agreement between me and the office.

Patient name_____

Patient Signature _____ Date _____

# *GENERAL DENTISTRY INFORMED CONSENT*

Patient_____.

1. **WORK TO BE DONE**
   I understand that I am having the following treatment done: Fillings____, Crowns____, Onlay____, Inlay____, Extractions____, Root canal____, Dentures/Partials____, Exam____, X-rays____, Prophy____, Other____, *(Pt Initials_____)*
2. **DRUGS AND MEDICATION**
   I understand that antibiotics , analgesics and other medications can cause allergic reactions causing redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock. *(Pt Initials_____)*
3. **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. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to may any/all changes and additions as necessary. *(Pt Initials_____)*
4. **REMOVAL OF TEETH**
   Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, ect.). I authorize the Dentist to remove the following teeth_____ and any others 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 that some more common of the risks involved in having teeth removed include pain, swelling, spread or development of infection, injury to adjacent teeth and/or restorations in other teeth, dry socket, loss of feeling and sensation in teeth, lips, tongue, and surrounding tissue (nerve damage) which can be temporary or permanent, fracture of the jaw and difficulty opening the jaw. 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. *(Pt Initials_____)*
5. **CROWNS,BRIDGES, CAPS, VENEERS, BONDING,ONLAY AND INLAY.**
   I understand that some of the risk of this procedure include, but are not limited to, abscess requiring additional treatment and recurrent decay requiring further treatment. 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 of easily and that I must be careful to ensure that they are kept on until permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement, recurrent cavities, gum disease, and may loose abutment teeth. This may necessitate a remake of crowns, bridges or caps. I understand there will be additional charges for remakes due to my delaying permanent cementation. *(Pt Initials_____)*
6. **ENDODONTIC TREATMENT (ROOT CANAL)**
   I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment which include, but are not limited to perforations of the tooth and root, and breakage of dental instruments in the canal of the tooth, I also understand that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stress vented 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 effort to save it. I also understand that additional risks include, but are not limited to, root fractures, undiagnosed ancillary canals and perforations. *(Pt Initials_____)*
7. **PERIODONTAL TREATMENT**
   I have a serious condition, causing gum and bone inflammation or loss that can lead to the loss of my teeth. Alternative treatment plans have been explained to me including, but not limited to, gum surgery, replacements and/pr extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. *(Pt Initials_____)*
8. **FILLINGS**
   I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required to additional decay. I understand that significant sensitivity is a common symptom after placement of a new filling. I also understand that if it is determined during that the decay is more extensive than first anticipated, additional treatment, including, but not limited to root canals or extractions may be necessary. I also understand that the risk include, but are not limited to, abscessed, infection and tooth fracture. *(Pt Initials_____)*
9. **DENTURES. COMPLETE OR PARTIAL**
   I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. 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, there will be additional charges. *(Pt Initials_____)*

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge no guarantee or assurance has been made by any one regarding the dental treatment which I have requested and authorized. I understand that no other Dentist is responsible for my dental treatment.

I here by authorize the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation, as well as attorneys fees and cost incurred by the dentist if I unsuccessfully assert a claim against any dentist for treatment I received at this office.

Signature of Patient:_____ Date:_____

Signature of Doctor:_____ Date:_____