**I. PATIENT INFORMATION & RESPONSIBLE PARTY** **DATE: _____**

**II. PATIENT INFORMATION:**

Patient Name_____ Please Circle: MINOR SINGLE MARRIED MALE FEMALE

Birthday _____ Social Security Number_____

If Full Time Student, School Name_____ Grade_____

**PERSON RESPONSIBLE FOR ACCOUNT: Please Circle: PATIENT GUARDIAN SPOUSE FATHER MOTHER**

Last Name_____ First Name_____ Middle Name_____

Street_____ City_____ State_____ Zip_____

Home Phone Number_____ Cell Phone Number_____

Social Security Number_____ State Drivers License Number_____

Dental Insurance Company_____

Subscriber #_____ Group #_____

Employer Name & Phone Number_____

Insured Birthday (MO/DAY/YR)_____

**III. PERSON TO CONTACT IN CASE OF EMERGENCY: Outside of Immediate Family**

Name_____ Telephone #_____

Address_____

**IV. MINOR CONSENT**

I give ***KAMRAN KASHIRAD, DDS*** permission to provide dental treatment to my son / daughter.
I understand changes in treatment plan may occur and I authorize necessary dental treatment.
I certify that I am the guardian of the child and have legal custody.

***Parent / Guardian***_____

**V. ASSIGNMENT OF INSURANCE BENEFITS**

I here by authorize payment directly to ***KAMRAN KASHIRAD, DDS*** the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I grant the right to ***KAMRAN KASHIRAD, DDS*** to release my dental / medical histories and other information to third party payors and / or other health professionals necessary.

***Signature***_____

**VI. DENTAL MATERIAL FACT SHEET**

I _____ acknowledge that I have had the opportunity to review / read or have received a copy of the Dental Materials Fact Sheet dated 10.17.01

***Signature***_____ ***Date:*** _____

**WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE: _____**

# KAMRAN KASHIRAD, DDS
## HEALTH HISTORY

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

### Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last Visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Are you happy with your smile? If no why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? _____ Yes No
Do you ever grind your teeth? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew tobacco? _____ Yes No
Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (Optional) _____
Date of last full mouth x-ray: _____

### Medical History

Are you under a physician's care now? If so, Why? _____
Name of Physician: _____ Phone number: _____
Have you ever been hospitalized or had a major operation? Discuss _____
Have you ever had a serious injury to your head or neck? Discuss _____
Are you taking any medications, pills or drugs? If so what? _____
Are you on a special diet? Discuss _____
Are you allergic to any medications or substances? If so please check box below:
☐ Aspirin ☐ Penicillin ☐ Acrylic ☐ Metal ☐ Latex ☐ Other: _____
Women (Please check): ☐ Pregnant ☐Nursing ☐ Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check appropriate boxes

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart Trouble/Disease | ☐ | ☐ | Bruise Easily | ☐ | ☐ | Emphysema | ☐ | ☐ | Yellow Jaundice | ☐ | ☐ |
| Cold Sores | ☐ | ☐ | heart murmur | ☐ | ☐ | Anemic | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Kidney Problems | ☐ | ☐ | Irregular heart beat | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Cancer | ☐ | ☐ |
| Renal dialysis | ☐ | ☐ | Herpes | ☐ | ☐ | Angina/Chest pain | ☐ | ☐ | Sickle cell disease | ☐ | ☐ |
| Radiation | ☐ | ☐ | Thyroid Disease | ☐ | ☐ | Stroke | ☐ | ☐ | Heart Attack | ☐ | ☐ |
| Hemophilia | ☐ | ☐ | Chemotherapy | ☐ | ☐ | Parathyroid Disease | ☐ | ☐ | Convulsions | ☐ | ☐ |
| Congenital heart Disorder | ☐ | ☐ | Leukemia | ☐ | ☐ | Intestinal Disease | ☐ | ☐ | Arthritis / Gout | ☐ | ☐ |
| Epilepsy or seizures | ☐ | ☐ | Ulcers | ☐ | ☐ | Rheumatism | ☐ | ☐ | Fainting/Dizziness | ☐ | ☐ |
| Recent blood transfusion | ☐ | ☐ | Scarlet Fever | ☐ | ☐ | Swelling of limbs | ☐ | ☐ | Pain in jaw joints | ☐ | ☐ |
| Recent weight loss | ☐ | ☐ | Glaucoma | ☐ | ☐ | Rheumatic fever | ☐ | ☐ | Lung Disease | ☐ | ☐ |
| Frequent Diarrhea | ☐ | ☐ | Cortisone Medicine | ☐ | ☐ | Tumors/Growths | ☐ | ☐ | Breathing Problem | ☐ | ☐ |
| Artificial heart valve | ☐ | ☐ | Diabetes | ☐ | ☐ | Artificial joint | ☐ | ☐ | Nervousness | ☐ | ☐ |
| Heart pace maker | ☐ | ☐ | Excessive thirst | ☐ | ☐ | Venereal disease | ☐ | ☐ | Psychiatric care | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ | Heart surgery | ☐ | ☐ | Frequent cough | ☐ | ☐ | Hypoglycemia | ☐ | ☐ |
| AIDS | ☐ | ☐ | Alzheimer's | ☐ | ☐ | Hay Fever | ☐ | ☐ | Liver Disease | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | HIV positive | ☐ | ☐ | Sinus trouble | ☐ | ☐ | Hepatitis A | ☐ | ☐ |
| Low blood pressure | ☐ | ☐ | Genital herpes | ☐ | ☐ | Blood disease | ☐ | ☐ | Asthma | ☐ | ☐ |
| Drug addiction | ☐ | ☐ | Hives or rash | ☐ | ☐ | Bloody sputum | ☐ | ☐ | Night sweats | ☐ | ☐ |
| Hepatitis B or C | ☐ | ☐ | Allergies | ☐ | ☐ | (Explain): _____ | | | | | |

Have you ever had any other serious illness not checked above? If so, Discuss _____
Do you wish to talk to the dentist privately about any problem? _____

To the best of my knowledge all the preceding answers are correct. If I have any changes in my health status or if any medicines change, I shall inform the dentist at the next appointment.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____

# Dental Treatment Consent Form

Please read and sign at the bottom of this form.

**DRUGS & MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (sever allergic reaction). Do not drive or operate heavy machinery while under the effects of dental narcotic analgesics.

**USE OF DENTAL ANESTHETIC**

I understand that use of anesthetic can cause an increase in heart rate, feeling of faintness, drowsiness, and heart palpitations. I am also aware of the minimal risk for nerve injury that may cause numbness in my teeth, lips, tongue, and surrounding tissues that can last for an indefinite period of time.

**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.

**DENTAL INSURANCE**

Please understand that dental insurance is a contract between you, your insurance carrier, and your employer. We will help in every way we can in filing your claim, however, you are responsible for all dental fees in the event your insurance company denies coverage, eligibility, and/or payment. Please be aware that we are only able to estimate your co-payment due to periodic changes within their contracts. You are responsible for insuring your eligibility with your dental insurance company each time dental service is provided.

**ARBITRATION AGREEMENT**

I understand that any dispute as to medical/dental malpractice, that is, as to whether any medical/dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law.

I understand that dentistry is not an exact science and that, 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. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____ _____

Signature of Patient/Guardian Date

# *Financial Policy*

Thank you for choosing ***Kamran Kashirad, DDS*** as your dental health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

**FULL PAYMENT IS DUE AT TIME OF SERVICE.**

We accept: **CareCredit Payment Plan, Visa, MasterCard, Checks & Cash.**

**Regarding Insurance**
We will accept assignment of insurance benefits, however, please understand that your dental insurance is a contract between you and your employer / insurance carrier. The account balance is your responsibility whether your insurance company reduces the estimated payment or denies your claim. In the event we do accept assignment of benefits, we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will be automatically be transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance plan.
Regarding Insurance Plans where we are a participating provider: All co-pays and deductibles are due prior to or at the time of treatment.

**Usual & Customary Rates**
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Adult Patients**
Adult patients are responsible for full payment at time of service.

**Minor Patients**
The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa / MasterCard, or cash payment at time of service has been verified.

**Missed Appointments**
Unless canceled, at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments, or providing 48 hour notice.

**Interest**
We reserve the right to charge interest in the amount of 18% as provided by state law.

**Collections**
In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs & reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

***I have read, and I understand and agree to this Financial Policy.***

***X*_____ *Date:* _____**

***Signature of Patient or Responsible Party***