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: PATIF	ENT GUARDIAN SPOUSE FATHER MOTHER			
Last Name	First Name	Middle Name			
Street	City	State Zip			
Home Phone Number	C	ell Phone Number			
Social Security Number	St	ate Drivers License Number			
Dental Insurance Company					
Subscriber #		Group #			
Employer Name & Phone Number					
Insured Birthday (MO/DAY/YR)					
		Outside of Immediate Family  Telephone #			
IV. MINOR CONSENT					
I give <i>KAMRAN KASHIRAD</i> , <i>DDS</i> permission to I understand changes in treatment plan may occur I certify that I am the guardian of the child and ha	and I authorize necessary				
Parent / Guardian					
V. ASSIGNMENT OF INSURANCE BE	NEFITS				
I here by authorize payment directly to <i>KAMRAN</i> understand that I am responsible for all costs of dedental / medical histories and other information to	ental treatment. I grant th	group insurance benefits otherwise payable to me. I the right to <b>KAMRAN KASHIRAD</b> , <b>DDS</b> to release my or other health professionals necessary.			
Signature					
VI. DENTAL MATERIAL FACT SHEE	Т				
Ireceived a copy of the Dental Materials Fact Shee	acknowledge that dated 10.17.01	t I have had the opportunity to review / read or have			
Signature		Date:			
WHO CAN WE THANK FOR REFERRING Y	YOU TO OUR OFFICE	:			



# KAMRAN KASHIRAD, DDS HEALTH HISTORY

Do you have a specific dental problem? Describe Do you have a specific dental problem? Describe Do you that dental examinations on a routine basis? I ast Visit Do you think you have active decay or gum disease? Do you push and floss on a routine basis? Discuss Do your gums ever bleed? Discuss Do you want to keep your remaining 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 Do you smoke or chew tobacco? Any sores or growths in your mouth? Discuss Do you smoke or chew tobacco? 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.  Are you on a special diet? Discuss Are you now have or have you ever had any of the following? 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 Heart Trouble/Disease Colid Sares heart murmur Anema Anemic Tableysease Convulsions  Herry of the precipital Acrylic Metal Experimental Disease Check Disease Angina Chest pain Sickle cell disease Kidney Problems Irregular heart beat Expessive Bleeding Cancer  Frequent Diarreta  Yes No Y	PATIENT NAME			DATE	
Do you have a specific dental problem? Describe Do you have a specific dental problem? Describe Do you that dental examinations on a routine basis? Last Visit Do you think you have active decay or gum disease? Do you push and floss on a routine basis? Discuss Do your gums ever bleed? Discuss Do you want to keep your remaining 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 Do you smoke or chew tobacco? Any sores or growths in your mouth? Discuss Do you smoke or chew tobacco? Yes No Do you smoke or chew tobacco? 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: Have you ever had a serious injury to your head or neck? Discuss Have you ever had a serious injury to your head or neck? Discuss Are you on a special diet? Discuss Are you on a special diet? Discuss Are you on a special diet? Discuss Are you now have or have you ever had any of the following? Please check box below: Aspirin Penicillin Acrylic Metal Latex Other: Aspirin Penicillin Acrylic Metal Latex Other: Anemie Trouble/Disease Cold Sares heart murmur Anemie Taking oral contraceptives  Do you now have or have you ever had any of the following? Please check appropriate boxes  Yes No Heart Trouble/Disease Cold Sares Heart Hurmur Anemie Taking oral contraceptives  Do you now have or have you ever had any of the following? Please check appropriate boxes  Yes No Heart Trouble/Disease Cold Sares Heart Hurmury Anemie Taking oral contraceptives  Do you mow have or have you ever had any of the following? Please check appropriate boxes  Yes No Heart Trouble/Disease Cold Sares Heart Hurmury Anemie Taking oral contraceptives  Do you	Primary reason for this dental appo	intment: Examination	n Emergency	Consultation	
Do you have a specific dental problem? Describe Do you have a specific dental problem? Describe Do you that dental examinations on a routine basis? Last Visit Do you think you have active decay or gum disease? Do you push and floss on a routine basis? Discuss Do your gums ever bleed? Discuss Do you want to keep your remaining 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 Do you smoke or chew tobacco? Any sores or growths in your mouth? Discuss Do you smoke or chew tobacco? Yes No Do you smoke or chew tobacco? 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: Have you ever had a serious injury to your head or neck? Discuss Have you ever had a serious injury to your head or neck? Discuss Are you on a special diet? Discuss Are you on a special diet? Discuss Are you on a special diet? Discuss Are you now have or have you ever had any of the following? Please check box below: Aspirin Penicillin Acrylic Metal Latex Other: Aspirin Penicillin Acrylic Metal Latex Other: Anemie Trouble/Disease Cold Sares heart murmur Anemie Taking oral contraceptives  Do you now have or have you ever had any of the following? Please check appropriate boxes  Yes No Heart Trouble/Disease Cold Sares Heart Hurmur Anemie Taking oral contraceptives  Do you now have or have you ever had any of the following? Please check appropriate boxes  Yes No Heart Trouble/Disease Cold Sares Heart Hurmury Anemie Taking oral contraceptives  Do you mow have or have you ever had any of the following? Please check appropriate boxes  Yes No Heart Trouble/Disease Cold Sares Heart Hurmury Anemie Taking oral contraceptives  Do you	<b>Dental History</b>				Please Circle
Do you have dental examinations on a routine basis? Last Visit Yes No Doy up thinky out have active decay or gum disease? Yes No Doy you brush and floss on a routine basis? Discuss Yes No Doy your gums ever bleed? Discuss Yes No Are you happy with your smile? If no why? Yes No Doy your gums ever bleed? Discuss Yes No Are you happy with your smile? If no why? Yes No Doy you want to keep your remaining teeth? Any loose teeth? Yes No Doy you want to keep your remaining teeth? Any loose teeth? Yes No Doy you ever bare clicking, popping or discomfort in the jaw joint? Yes No Doy you ever gind your teeth? Any loose teeth? Yes No Doy you gast experiences in a dental office always been positive? Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Any sores or growths in your mouth? Discuss Yes No Are you alteried or had a major operation? Discuss Yes No Yes No Are you alteried or had a major operation? Discuss Are you alteried to any medications, pills or drugs? If so what?  Are you alteried to any medications or substances? If so please check box below:  Aspirin Penicillin Acrylic Metal Latex Other:  Are you on a special diet? Discuss Yes No					
Do you brink you have active decay or gum disease?  Do you brush and floss on a routine basis? Discuss  Do you purban and floss on a routine basis? Discuss  Are you happy with your smile? If no why?  Does food catch between your teeth? Any loose teeth?  Do you ever have clicking, popping or discomfort in the jaw joint?  Do you ever have clicking, popping or discomfort in the jaw joint?  Do you ever have clicking, popping or discomfort in the jaw joint?  Do you ever have clicking, popping or discomfort in the jaw joint?  Do you smoke or chew tobacco?  Yes No any sores or growths in your mouth? Discuss  Have your past experiences in a dental office always been positive?  Ves No Any sores or growths in your mouth? Discuss  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's Phone number:  Have you ever heen hospitalized or had a major operation? Discuss  Have you ever heen hospitalized or had a major operation? Discuss  Are you a special diet? Discuss  Are you alterige to any medications or substances? If so what?  Are you on a special diet? Discuss  Are you on a special diet? Discuss  Are you on a precial diet? Discuss  Are you on a special diet? Discuss  Are you on a precial diet? Discuss  Are you taken any medications or substances? If so what?  Are you on a special diet? Discuss  Are you delenged to any medications or substances? If so what?  Are you on a special diet? Discuss  Are you delenged to any medications or substances? If so what?  Are you on a special diet? Discuss  Are you discuss any medications or substances? If so what?  Are you on a special diet? Discuss and the your discuss and you have a precial discuss and you have a pre	Do you have dental examinations o	Yes No			
Do you brish and floss on a routine basis? Discuss	Do you think you have active decay	v or gum disease?			Yes No
Do you gums ever bleed? Discuss Are you happy with your smile? If no why? Does food catch between your teeth? Any loose teeth? Do you want to keep your remaining teeth? Do you want to keep your remaining teeth? Do you want to keep your remaining teeth? Do you swer have clicking, popping or discomfort in the jaw joint? Do you swoke or chew tobacco? Are you smoke or chew tobacco? Ves No 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: Have you over had a serious injury to your head or neck? Discuss Have you over had a serious injury to your head or neck? Discuss Have you over head a serious injury to your head or neck? Discuss Have you over head a serious injury to your head or neck? Discuss Have you over head a serious injury to your head or neck? Discuss Have you over head a serious injury to your head or neck? Discuss Have you over head a serious injury to your head or neck? Discuss Are you a lallergic to any medications or substances? If so please check box below: Aspirin Penicillin Acrylic Metal Nursing Taking oral contraceptives  Do you now have or have you ever had any of the following? Please check appropriate boxes  Do you now have or have you ever had any of the following? Please check appropriate boxes  Ves No Heart Trouble/Disease Cold Sores Bruise Easily Fregular heart beat Fregular heart heart Fregular heart heart Fregular heart heart Fregular h	Do you brush and floss on a routine	e basis? Discuss			Yes No
Are you happy with your smile? If no why?  Do you want to keep your remaining teeth?  Do you want to keep your remaining teeth?  Do you want to keep your remaining teeth?  Do you ever grind your teeth?  Any loos teeth?  Do you ever bare clicking, popping of discomfort in the jaw joint?  Do you smoke or chew tobacco?  Any sores or growths in your mouth? Discuss  Name of previous dentist (Optional)  Date of last full mouth x-ray:    Wedical History  Are you under a physician's care now? If so, Why?  Name of Previous dentist (Optional)  Date of last full mouth x-ray:    Wedical History  Are you taking any medications, pills or drugs? If so what?  Are you under a physician's care now? If so, Why?  Name of Physician.  Have you ever head a senious injury to your head or neck? Discuss  Have you ever head a senious injury to your head or neck? Discuss  Have you ever head a senious injury to your head or neck? Discuss  Have you ever head a senious injury to your head or neck? Discuss  Have you ever head a senious injury to your head or neck? Discuss  Have you ever head a senious injury to your head or neck? Discuss  Have you ever head a senious injury to your head or neck? Discuss  Have you ever head a senious injury to your head or neck? Discuss  Have you ever head a senious injury to your head or neck? Discuss  Have you ever head a senious injury to your head or neck? Discuss  Are you allergic to any medications or substances? If so please check box below:  Aspirin Penicillin Acrylic Metal Latex Other:  Are you allergic to any medications or substances? If so please check appropriate boxes  Yes No  Yes No	Do your gums ever bleed? Discuss				Yes No
Does tood action between your teeth? Any toose 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 have clicking, popping or discomfort in the jaw joint? Yes No Do you shour or chew tobacco? Yes No Do you so not or chew tobacco? Yes No Do you some or chew tobacco? Yes No Any sores or growths in your mouth? Discuss Name of previous dentist (Optional) Date of last full mouth x-ray:    Medical History	Are you happy with your smile? If	no why?			Yes No
Do you want to keep your remaining teeth?  Yes No Do you ever grind your teeth?  Yes No Do you ever grind your teeth?  Yes No Do you sery be a dental office always been positive?  Yes No Do you smoke or chew tobacco?  Any sores or growths in your mouth? Discuss  Any sores or growths in your mouth? Discuss  No Name of previous dentist (Optional)  Date of last full mouth x-ray:	Does food catch between your teeth	n? Any loose teeth?			Yes No
Do you ever have clicking, popping or discomfort in the jaw joint?  Do you ever parind your teeth?  Have your past experiences in a dental office always been positive?  Do you smoke or chew tobacco?  Any sores or growths in your mouth? Discuss 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:  Have you ever had a serious injury to your head or neck? Discuss Have you ever head a serious injury to your head or neck? Discuss Have you ever head a serious injury to your head or neck? Discuss Are you allergic to any medications, pills or durgs? If so what?  Are you allergic to any medications or substances? If so please check box below:  Aspirin Penicillin Acrylic Metal Latex Other:  Women (Please check):  Do you now have or have you ever had any of the following? Please check appropriate boxes  Yes No  Through Disease  Cold Sores  Heart Trouble/Disease  Cold Sores  Namian Throuble/Disease  Cold Sores  Namian T	B 1	1.0			77 37
Do you ever grind your teeth?  Aleave your past experiences in a dental office always been positive?  Do you smoke or chew tobacco?  Any sores or growths in your mouth? Discuss  Name of previous dentist (Optional)  Date of last full mouth x-ray:    Wedical History   Name of Physician:	Do you ever have clicking, popping	or discomfort in the jay	v ioint?		Yes No
Have your past experiences in a dental office always been positive?					
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Name of previous dentist (Optional) Date of last full mouth x-ray:    Medical History	Do you smoke or chew tobacco?	Р			Yes No
Name of previous dentist (Optional) Date of last full mouth x-ray:    Medical History	Any sores or growths in your mout	h? Discuss			Yes No
Medical History Are you under a physician's care now? If so, Why? Name of Physician: 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: 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  Heart Trouble/Disease Cold Sores heart murmur Anemic Tuberculosis Kidney Problems Irregular heart beat Excessive Bleeding Cancer Renal dialysis Herpes Angina/Chest pain Sickle cell disease Renal dialysis Herpes Angina/Chest pain Sickle cell disease 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 Rheumatis flever Lung Disease Frequent Diarrhea Cortisone Medicine Tumors/Growths Breathing Problem Artificial point Nervousness Heart surgery Frequent cough Hypoglycemia Labelmen Shortness of breath Heart surgery Frequent cough Hypoglycemia Low blood pressure Genital hereps Blood disease Asthma AlbS Alzheimer's Hay Fever Liver Disease Hay bout 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. 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.  The tr	Name of previous dentist (Optional	)			
Are you under a physician's care now? If so, Why? Name of Physician:  Have you ever been hospitalized or had a major operation? Discuss Have you ever bean hospitalized or had a major operation? 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:  Momen (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 Heart Trouble/Disease  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 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 Problems  Artificial heart valve Diabetes Artificial joint Nervousness  Heart apea maker Excessive thirst Venereal disease Psychiatric care Shelingh blood pressure Genital herpes Blood disease Asthma Night sweats  Hay Fever Liver Disease  Drug addiction Hives or rash Blood ysputum Night sweats  Helatitis B or C Allergies (Explain):  To the best of my knowledge all the preceding anowers 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. Ax  Pattlett SIGNATURE (PARENT OR GUARDIAN)	Date of last full mouth x-ray:				
Are you under a physician's care now? If so, Why?    Name of Physician:			<del> </del>		
Are you under a physician's care now? If so, Why?    Name of Physician:	Medical History				
Name of Physician:		over 1f an Whyer			
Have you ever had a serious injury to your head of neck? Discuss   Are you taling any medications, pills or drugs? If so what?   Are you altergic to any medications or substances? If so please check box below:   Aspirin   Penicillin   Acrylic   Metal   Latex   Other:    Aspirin   Penicillin   Acrylic   Metal   Latex   Other:    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   Yes No   Heart Trouble/Disease   Bruise Easily   Emphysema   Yellow Jaundice   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   Congenital heart Disorder   Leukemia   Intestinal 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 asurgery   Frequent cough   Hypoglycemia   AIDS   Alzheimer's   Hay Fever   Liver Disease   Horten Disease   Asthma   Drug addiction   Hives or rash   Blood disease   Asthma   Drug addiction   Hives or rash   Blood ysputum   Night sweats   Heart the next appointment.   X   PATIENT SIGNATURE (PARENT OR GUARDIAN)	Name of Dhygician	Dhone n			-
Have you ever had a serious injury to your head of neck? Discuss   Are you taling any medications, pills or drugs? If so what?   Are you altergic to any medications or substances? If so please check box below:   Aspirin	Name of Physician:	Pnone n	iumber:		_
Are you alking 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	Have you ever been hospitalized or	had a major operation?	Discuss		_
Are you allergic to any medications or substances? If so please check box below:     Aspirin Penicillin Acrylic Metal Latex Other:     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	Have you ever had a serious injury	to your head or neck? D	iscuss		<u> </u>
Aspirin Penicillin Acrylic Metal Latex Other:	Are you taking any medications, pi	lls or drugs? If so what?			<u> </u>
Aspirin Penicillin Acrylic Metal Latex Other:	Are you on a special diet? Discuss				
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 N					
Yes No Heart Trouble/Disease Bruise Easily Emphysema Yellow Jaundice 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 AlDS 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):  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		Acrylic	Metal	Latex	Other:
Yes No Heart Trouble/Disease Bruise Easily Anemic 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 Recent blood transfusion Recent blood transfusion Scarlet Fever Swelling of limbs Recent weight loss Glaucoma Rheumatic fever Lung Disease Frequent Diarrhea Cortisone Medicine Tumors/Growths Breathing Problem Artificial heart valve Diabetes Artificial joint Nervousness Shortness of breath Heart surgery Frequent cough Hypoglycemia AIDS Alzheimer's Hay Fever Liver Disease 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 Frequent pate in 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.  PATIENT SIGNATURE (PARENT OR GUARDIAN)	Women (Please check):	Pregnant	Nursing	Taking oral cor	ntraceptives
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 Genital herpes Blood disease Asthma Drug addiction Hives or rash Bloody sputtum Night sweats Heave 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 PATIENT SIGNATURE (PARENT OR GUARDIAN)	Do you now have or have you e	ever had any of the follower	lowing? Please cl	heck appropriate l	boxes
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):  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)	Yes N	lo	Yes No	Yes No	Yes No
Kidney Problems 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 Recent Disease Painting/Dizziness Recent blood transfusion Recent weight loss Glaucoma Rheumatic fever Guent Diarrhea Cortisone Medicine Tumors/Growths Breathing Problem Artificial heart valve Diabetes Heart valve Diabetes Artificial joint Nervousness Heart pace maker Skoessive 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 Heye 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?  PATIENT SIGNATURE (PARENT OR GUARDIAN)	Heart Trouble/Disease	Bruise Easily	Emphys	ema	Yellow Jaundice
Renal dialysis	Cold Sores	heart murmur	Anemic		Tuberculosis
Renal dialysis	Kidney Problems	Irregular heart beat	Excessiv	e Bleeding	Cancer
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)	Renal dialysis				Sickle cell disease
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.  PATIENT SIGNATURE (PARENT OR GUARDIAN)	Radiation	Thyroid Disease		•	Heart Attack
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  HilV positive  Sinus trouble  Hepatitis A  Low blood pressure  Genital herpes  Blood disease  Asthma  Drug addiction  Hives or rash  Bloody sputum  Night sweats  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  PATIENT SIGNATURE (PARENT OR GUARDIAN)	Hemophilia		Parathyr	oid Disease	Convulsions
Epilepsy or seizures  Recent blood transfusion  Recent weight loss  Glaucoma  Rheumatic fever  Lung Disease  Frequent Diarrhea  Cortisone Medicine  Tumors/Growths  Breathing Problem  Artificial heart valve  Diabetes  Heart pace maker  Excessive thirst  Venereal disease  Psychiatric care  Shortness of breath  Heart surgery  Frequent cough  Hypoglycemia  Alzheimer's  HIV positive  Liver Disease  HIV positive  Sinus trouble  Hepatitis A  Low blood pressure  Genital herpes  Blood disease  Asthma  Drug addiction  Hives or rash  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.  PATIENT SIGNATURE (PARENT OR GUARDIAN)	•	* *			Arthritis / Gout
Recent blood transfusion Recent weight loss Glaucoma Rheumatic fever 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 AlDS Alzheimer's Hay Fever Liver Disease High blood pressure Hilv positive Sinus trouble Hepatitis A Low blood pressure Genital herpes Blood disease Asthma Drug addiction Hives or rash 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.  PATIENT SIGNATURE (PARENT OR GUARDIAN)	•	Ulcers	Rheuma	tism	Fainting/Dizziness
Recent weight loss Glaucoma Rheumatic fever 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 AlDS 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 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.  PATIENT SIGNATURE (PARENT OR GUARDIAN)	Recent blood transfusion				
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  AlDS  Alzheimer's  Hay Fever  Liver Disease  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.  Date  PATIENT SIGNATURE (PARENT OR GUARDIAN)					
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Heart pace maker  Excessive thirst  Venereal disease  Psychiatric care  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  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  PATIENT SIGNATURE (PARENT OR GUARDIAN)					
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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 PATIENT SIGNATURE (PARENT OR GUARDIAN)	· ·				
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Do you wish to talk to the dentist privately about any problem?	Hepatitis B or C	Allergies	(Explain): _		
X Date PATIENT SIGNATURE (PARENT OR GUARDIAN)	Have you ever had any other seriou Do you wish to talk to the dentist p	s illness not checked aborivately about any proble	ove? If so, Discuss em?		
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Reviewed By Doctor 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.

satisfaction. Teoliscit 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: