Century Smile
Maryam Talaie, D.D.S.
9916
Venice Blvd
Culver City,
CA 90232

Reason for Today's Visit:_____ Date:_____

Name: _____ Sex: ___ M ____F Date of Birth:_____
Home Phone:_____Work Phone:_____ Cell Phone:_____
Email Address:_____ Patient Social Security #:_____
Home Address:_____ City:_____ State/Zip:_____

Whom may we contact in the case of an emergency? _____ Phone:_____

Whom may we thank for referring you to us? _____

Who is responsible for this account?_____ Date of last dental exam:_____
Name of previous treating dentist:_____ Phone:_____
Location:_____

Are you currently employed? □Yes □No Name of Employer:_____

Dental Insurance Carrier Name:_____ Phone #:_____

Name of MAIN subscriber:_____ ID #:_____
Group #:_____
Relationship to Patient: ***self*** ***other*** Name and relation:_____

Are the medical and dental carrier the same? □Yes □No

Is this plan **HMO, PPO or EPO** (circle the correct response)

Secondary or suplimental dental coverage? □Yes □No
If yes, please provide details:_____

Medical insurance policy? □Yes □No *please provide office with copy of Insurance card*

Insurance Authorization:
I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the dentist to release all information necessary to secure the payment of beneifts. I understand that I am financially responsible for all charges whether or not paid by insurance.
□Yes □No **Initial:**_____

Corespondence and electronic communication:
I authorize my dentist to electronically submit corespondence related my dental care, such as x-rays, photos, recommended treatment, conditions, appointments or any other pertinent information related to my dental/medical care. This includes communication via telephone, fax and e-mail with insurance companies, and or other healthcare providers.
□Yes □No **Initial:**_____

Medical History

Indicate which of the following conditions you have or have had.

*No Epi	□Yes □No	Anemia	□Yes □No	Endocarditis	□Yes □No
Allergy-Aspirin	□Yes □No	Anti-Depressants	□Yes □No	Fainting	□Yes □No
Allergy-Ibuprofen	□Yes □No	Artificial Joints	□Yes □No	Heachaches /TMJ	□Yes □No
Allergy-Codeine	□Yes □No	Artificial Valve	□Yes □No	Heart Murmur/MVP	□Yes □No
Allergy-Erythro	□Yes □No	Arthritis	□Yes □No	Eating Disorder	□Yes □No
Allergy-Latex	□Yes □No	Biophosphonates	□Yes □No	Epilespsy	□Yes □No
Allergy-Metals	□Yes □No	Blood Disease	□Yes □No	Glaucoma	□Yes □No
Allergy-Penicillin	□Yes □No	Blood Thinners	□Yes □No	Heart Disease	□Yes □No
Allergy-Sulfa	□Yes □No	Blood Transfusion	□Yes □No	Hepatitis	□Yes □No
Allergy-other	□Yes □No	Cancer	□Yes □No	Herpes	□Yes □No
COPD	□Yes □No	Cortisone Therapy	□Yes □No	High Blood Pressure	□Yes □No
Diabetes	□Yes □No	Dry Mouth	□Yes □No	HIV	□Yes □No
Kidney Disease	□Yes □No	Liver Disease	□Yes □No	Low Blood Pressure	□Yes □No
Lupus	□Yes □No	Mental Disorder	□Yes □No	Migraines	□Yes □No
Birth Control	□Yes □No	Pacemaker	□Yes □No	Radiation/Chemo	□Yes □No
Sinus Problems	□Yes □No	STD's	□Yes □No	Stroke	□Yes □No
Substance Abuse	□Yes □No	Tabacco Use	□Yes □No	Tuberculosis	□Yes □No
Tumors	□Yes □No	Ulcer	□Yes □No	Thyroid problems	□Yes □No

If any conditions or alerts selected above need further clarification, please describe:_____

_____

_____

Rate your general health: ***Excellent*** ***Good*** ***Fair*** ***Poor***

Do you need to take antibiotic premedication for your dental visits? If Yes, Please explain:_____

_____

Name of your physician, phone number, and your most recent physical exam: _____

_____

_____

Describe any current medical treatment, impending surgery,or other treatment that may possibly affect your dental treatment:_____

_____

_____

List all medication, drugs, pills or herbal remedies, including regular dosages of asprin:_____

_____

_____

_____

**I acknowledge that I have reviewed ALL questions/alerts on this form and responded accordingly.*
There are no other conditions or medications/allergies that have not been listed. I am aware that I must notify The practice of any future changes.

Intial:_____

Dental History

Rate your oral health: ***Excellent*** ***Good*** ***Fair*** ***Poor***

Previous dentist: _____ Location:_____ Phone:_____ e-mail:_____
Most recent exam:_____ Most recent X-rays: _____
What is your immediate concern?_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10(most)

Personal History, check all that apply:

Had a unfavorable dental experience
Had trouble getting numb
Had/ have braces, orthodontic treatment
Had teeth removed
Had complications from past dental treatment
Had any reactions to local anesthetic
Had your bite adjusted

Smile Characteristics, check all that apply:

Is there anything about the apperance of your teeth that you would like to change?
Have you ever whitened/bleached your teeth?
Have you felt uncomfortable or self conscious about the apperance of your teeth?
Have you been disapopointed with the apperance of previous dental work?
Do you have metal crowns or fillings?

Bite and Jaw Joint, check all that apply:

You have problems with your jaw joint
You have problems chewing
Your teeth changed in the last 5 years, becoming shorter, thinner or worn
Your teeth are crowding or developing spaces
You clench your teeth in the daytime or make them sore
You have problems with sleep or wake up with an awareness of your teeth
You wear or have worn a bite appliance
You snore
You feel tired through out the day, even after 8 hours of sleep
You have been diagnosed with sleep apnea

Tooth structure, check all that apply:

Cavities within past 3 years
The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
Grooves or notches on your teeth, chipped teeth, or has a toothache or cracked filling
Food gets caught between teeth

Gum and Bone, check all that apply:

Gums bleed when brushing or flossing
Treated for gum disease or were told you have lost bone around your teeth
Noticed an unpleasant taste or odor in your mouth
History of periodontal disease in your family

Dental History

If any checked boxes need further explanation, please describe:

HIPPA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.
I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting it confifentiality.

Initial_____ ***By initialing, I understand the above information and agree with its contents, and this will serve as my signature for the HIPPA Disclosure form***

Financial Policy

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibilty on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangments, must be paid for at the time of services are performed unless other arrangements are made.
Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will bill the insurance company, and send necessary documentation but the patient is responsible for any unpaid portion of a claim. We send pre-authorizations and or estimate a patient's out-of -pocket co-pay for services based on information provided by your dental plan. As per dental insurance companies, estimates are not a guarrentee of payment until a claim is received. All balances are due within 60 days unless arrangments are made with the office manager or Doctor.
A late fee of $5.00 will be charged to my account every 30 days until balance is paid. Accounts will be sent to our 3rd party collection agency after 90 days. Communication with the office manager regarding billing and account balances may prevent such action.
In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services. I understand one time payment arrangments can be made to assist in finishing dental treatment.
I understand that 3rd party financing payment plans may also be available. I understand that if I lose my dental coverage the office may work with me to help maintain my dental care until a new policy is in place.

Initial_____ ***By initialing, I understand the above information and agree with its contents, and this will serve as my signature for the administration form***

Care to Share

The greatest gift a patient can give is a referral of a friend or family member. **If you recommend our practice to a family and friends, we will apply a $50.00 credit to their account** that can be used applied to any services. We will also **send you a pair of complimentary movie tickets**, courtesy of AMC Theaters. Just have your friend or family member mention your name when calling to schedule a first time appointment. After your first patient referral, **you will receive $50.00 credit for every patient referred thereafter**.

Appointments

We understand that unplanned issues can come up and you may need to cancel an appointment. However, if that happens to be the case, we respectfully ask for scheduled appointments to be cancelled or rescheduled **at least 48 hours in advance in order for us to better accommodate others. A fee of $100 per hour may be applied for last minute cancelations or no-shows.** If you are running late to an appointment, please call or e-mail us asap so we can better adjust our schedule. In some cases we will still be able to see you but we may have to reschdule. We text, e-mail and call patients to confirm/remind of their appointments. If you confirm via any of these methods, you may still receive another reminder but you do not have to confirm multiple times. If you do not want to receive text reminders or e-mails, please let the front desk know. **Appointments scheduled for two hours or longer, require a deposit of the entire estimated co-pay or portion of.** E-mail corespondence with the practice can be the most efficent way to communicate regarding appointments, billing or treatment related questions.

Treatment or Billing Disputes

We appreciate all forms of feedback regarding your experience with our dental practice.
A successful patient/doctor relationship is built on trust and communication. **If you feel concerned or need clarity about anything related your dental treatment, scheduling or billing, please address it with the doctor or manger as soon as possible**. Other than finding a solution to the issue, we can use the occurrence as a learning opportunity to better serve patients and avoid any future disputes. If you feel you are not happy with services provided or if there are any other concerns, **we will address and resolve it immediately**.

Patient or Guardian:

Print Name_____

Signature_____ Date:_____