Century Smile

Maryam Talaie, D.D.S.

Pre-Appointment Patient Screening

Question	PRE-APPOINTMENT	IN-OFFICE
Do you/they have fever or have you/they felt hot or feverish recently 14-21 days)?	◯ Yes ◯ No	◯ Yes ◯ No
Are you/they having shortness of breath or other difficulties breathing?	◯ Yes ◯ No	◯ Yes ◯ No
Do you/they have a cough?	◯ Yes ◯ No	◯ Yes ◯ No
Any other flu-like symptoms, such as gastrointestinal upset,	◯ Yes ◯ No	◯ Yes ◯ No
Have you/they experienced recent loss of taste or smell?	◯ Yes ◯ No	◯ Yes ◯ No
Are you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	◯ Yes ◯ No	◯ Yes ◯ No
Is your/their age over 60?	◯ Yes ◯ No	◯ Yes ◯ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	◯ Yes ◯ No	◯ Yes ◯ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	◯ Yes ◯ No	◯ Yes ◯ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

3831 Hughes Ave, Suite 701 | Culver City, CA 90232 Office (310) 836-6161

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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 supplemental 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 benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

◯ Yes ◯ No Initial: ____________

Correspondence and electronic communication:

I authorize my dentist to electronically submit correspondence 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: ____________

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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	No Anti-Depressants	◯ Yes	◯ No	No Fainting	◯ Yes	◯ No
Allergy-Ibuprofen	◯ Yes	◯ No	Artificial Joints	◯ Yes	◯ No	No Headaches /TMJ	◯ Yes	◯ No
Allergy-Codeine	◯ Yes	◯ No	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	Bisphosphonates	◯ Yes	◯ No	Epilepsy	◯ Yes	◯ No
Allergy-Metals	◯ Yes	◯ No	Blood Disease	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No
Allergy-Penicillin	◯ Yes	◯ No	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	Tabaco 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: ______________________

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

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

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

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

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List all medication, drugs, pills or herbal remedies, including regular dosages of aspirin: ______________________

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*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.

Initial: ______________________________

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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 appearance 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 appearance of your teeth?
- ◯ Have you been disappointed with the appearance 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

If any checked boxes need further explanation, please describe:

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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 confidentiality.

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 responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, 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 guarantee of payment until a claim is received. All balances are due within 60 days unless arrangements 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 arrangements 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 cancellations or no-shows.

If you are running late to an appointment, please call or e-mail us a.s.a.p. so we can better adjust our schedule. In some cases we will still be able to see you but we may have to reschedule. 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 correspondence with the practice can be the most efficient 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: ____________

Any Additional Notes:

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical 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, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ______________________________ Patient's or Patient Representative's Signature (Date)

By: ______________________________ Physician's or Authorized Representative's (Date)