BITA DAVOODIAN DDS
Family and Cosmetic Dentistry

Patient Information

Patient Name: _____ Preferred Name _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Birth Date:_____Social Security #: _____

Phone (Home): _____ (Work):_____ Ext:____ (Cell):_____ (Email):_____

Preferred contact method for appointment confirmation: (Circle 1): Home# Work# Cell#

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Internet ☐ Other_____

Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____(Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

1959 Kingsdale Ave Suite 202 Redondo Beach CA 90278
310-793-1000

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Insured's Employer Name: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. As a courtesy to our patients, we will process your insurance claim for each visit and bill you for any remaining balance. Patients who carry dental insurance should understand that all dental services furnished are charged directly to the patient and that he or she is ultimately responsible for payment of all dental services. Our office does not participate with managed dental care insurance plans.

I understand that any fee estimates given for proposed dental treatment can only be honored for a period of twelve months from the date of the patient examination.

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

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of patient, parent or guardian

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of guarantor of payment/responsible party

NOTICE TO PATIENTS

PROPOSITION 65 WARNING: Dental Amalgam, used in many dental fillings, causes exposure to mercury, a chemical known to the state of California to cause birth defects or other reproductive harm.

I understand that Dr. Davoodian has advised me to review Proposition 65 required by the Federal and State regulations.

The U.S. Food and Drug Administration has studied the situation and approved for use all dental restorative materials. Consult your dentist to determine which materials are appropriate for your treatment.

I have received a copy of the Dental Materials Fact Sheet as required by law.

_____

PATIENT NAME

_____

PATIENT SIGNATURE

_____

DATE

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MEDICAL HEALTH QUESTIONAIRE

1. General Health (please check): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
2. Name and address of physician: _____
3. Last complete physical: _____
4. Has there been any change in your general health within the past year?.....☐YES☐NO
5. Are you now under the care of a physician?.....☐YES☐NO
   If so, what is the condition being treated? _____
6. Have you had any serious illness or operation in the past 5 years?.....☐YES☐NO
   If so, what was the illness or operation? _____
7. Have you been hospitalized for any serious illness within the past five (5) years?.....☐YES☐NO
   If so, what was the problem? _____
8. Do you use tobacco?.....☐YES☐NO
   If so, what type and what is your average daily usage? _____
9. Have you had any serious trouble associated with any previous dental treatment?.....☐YES☐NO
   If so, explain _____
10. Are you wearing contact lenses?.....☐YES☐NO

Do you have or have you had any of the following diseases or problems?: (Please check YES or NO)

Y N	Y N	Y N	Y N
☐ ☐ Abnormal or Prolonged Bleeding	☐ ☐ Congential Heart Leasion	☐ ☐ Herpes	☐ ☐ Rheumatic Fever
☐ ☐ AIDS or HIV Positive Test	☐ ☐ Coronary Artery Disease	☐ ☐ High Blood Pressure	☐ ☐ Scarlet Fever
☐ ☐ Allergies	☐ ☐ Damaged Heart Valve	☐ ☐ Hives or Skin Rash	☐ ☐ Sexually Transmitted Disease
☐ ☐ Anemia	☐ ☐ Diabetes	☐ ☐ Hip or Knee Replacement	☐ ☐ Sinus Problems
☐ ☐ Angina	☐ ☐ Fainting Spells or Seizures	☐ ☐ Inflammatory Rheumatism	☐ ☐ Sleep Apnea
☐ ☐ Arthritis	☐ ☐ Fever Blister	☐ ☐ Jaundice Or Liver Disease	☐ ☐ Snoring
☐ ☐ Artificial Heart Valve	☐ ☐ Hay Fever	☐ ☐ Kidney Problems	☐ ☐ Stomach Ulcers
☐ ☐ Asthma	☐ ☐ Head and Neck Radiation	☐ ☐ Low Blood Pressure	☐ ☐ Stroke
☐ ☐ Cancer or Tumor	☐ ☐ Hemophilia	☐ ☐ Mitral Valve Prolapse	☐ ☐ Systematic Steroid Treatment
☐ ☐ Cardiac Pacemaker	☐ ☐ Heart Attack	☐ ☐ Pacemaker	☐ ☐ Tuberculosis
☐ ☐ Cardiovascular Disease	☐ ☐ Heart Murmur	☐ ☐ Persistent Cough	
	☐ ☐ Hepatitis	☐ ☐ Radiation Treatment	

WOMEN:

1. Are you pregnant?.....☐ YES ☐ NO
2. Do you have any problems associated with your menstrual period?.....☐YES ☐NO
3. Are you nursing?.....☐YES ☐ NO
4. Are you taking oral contraceptives?.....☐YES ☐ NO

Please list any MEDICATION(S) (INCLUDING OVER-THE-COUNTER DRUGS) you currently take:

Medication	Dosage	For what purpose?	Medication	Dosage	For what purpose?

Please list any MEDICINE ALLERGIES AND REACTIONS you have had:

Medication	Reaction	Medication	Reaction

Do you have any disease, condition, or problem not listed above that you think I should know about.....☐YES ☐NO
If so, explain _____

To the best of my knowledge the above questions have been accurately answered.

PATIENT NAME (print)_____ DATE:_____

PATIENT SIGNATURE_____ DATE:_____

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ORAL AND DENTAL HEALTH QUESTIONAIRE

1. Chief Dental Concern_____
2. When was your last dental visit?_____For what purpose?_____
3. How frequently in the past have you had routine dental examinations? _____
4. Brushing frequency ( ) times per day Flossing frequency ( ) times per week
5. Have you ever been shown the proper way to brush and floss your teeth? ..... ☐ Yes ☐ No

HAVE YOU PREVIOUSLY HAD ANY OF THE FOLLOWING?: (check all that apply)

- ☐ Orthodontics(Braces)
- ☐ Wisdom Teeth Removed
- ☐ Periodontal (Gum) Treatment
- ☐ Nightguard or Retainer Appliance
- ☐ Removable Partial Denture(s)
- ☐ Trauma to a tooth (teeth)
- ☐ Trauma to the Jaw(s)

ARE ANY OF THE FOLLOWING CURRENT PROBLEMS FOR YOU?: (check all that apply)

- ☐ Tooth Cold Sensitivity
- ☐ Tooth Hot Sensitivity
- ☐ Tooth Sweet Sensitivity
- ☐ Tooth Chewing Discomfort
- ☐ Toothaches
- ☐ Loose Teeth
- ☐ Shifting Teeth
- ☐ Rough Or Broken Fillings
- ☐ "Food Traps" Between Teeth
- ☐ Bleeding Gums
- ☐ Swollen Gums
- ☐ Bad Breath Or Bad Taste
- ☐ Tooth Clenching Or Grinding During Day Or Night
- ☐ Tooth Wear Or Abrasion
- ☐ Frequent Headaches
- ☐ Jaw Joint Locking, Sticking, Or "Going Out"
- ☐ Jaw Joint "Clicking, Popping, Or Grating" Noises
- ☐ Jaw Joint, Face, Or Chewing Muscle Pain Or Tightness
- ☐ Snoring

6. Are you happy with the appearance of your teeth? ☐ Yes ☐ No

WHICH COSMETIC TOOTH CHANGES WOULD YOU BE INTERESTED IN DISCUSSING? (check all that apply)

- ☐ Improving Tooth Color
- ☐ AlteringTooth Shape
- ☐ Correcting Tooth Size
- ☐ Enhancing Teeth Brightness
- ☐ Correcting Teeth Spacing
- ☐ Correcting Teeth Crowding
- ☐ Replacing Missing Teeth
- ☐ Teeth Whitening (Bleaching)
- ☐ Replacing Unesthetic Crown(s) (i.e., "Caps")
- ☐ Replacing Silver (Black) Fillings With Tooth Colored Fillings

7. How important is it that you keep your remaining natural teeth for life?
   ☐ Very Important ☐ Not too Important ☐ Not Important at all
8. Have you been satisfied with the dental care you have received in the past? ☐ Yes ☐ No
   If No, Why?_____
9. Name and address of previous Dentist:_____

PATIENT SIGNATURE_____DATE _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, the Health Insurance Portability & Accountability Act of 1996 " Hippa" I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who maybe involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this ***Notice of Privacy Practices*** Acknowledgement, but was unable to do so as documented below.

Date:_____ **Initials**:_____ **Reason**: _____

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In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Mobile**:

- ☐ Okay to send text message
- ☐ Okay to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Home Telephone**:

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Work Telephone**:

- ☐ Okay to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Written communication**

- ☐ Okay to mail to my home address
- ☐ Okay to mail to my work/ office address
- ☐ Okay to fax to number indicated

I allow you to give my clinical information to or answer questions from (check all that apply):

☐ Spouse

☐ Parent

☐ Child

☐ Insurance

☐ Other (specify):

☐ None

Patient or Guardian Signature

Date

Print Name

Birth Date

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In reading and signing this form, it is understood that ENGLISH is the language that I understand and use to communicate.

1. DRUGS, MEDICATION AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty-four [24] hours after my release from surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia and/or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloral hydrate, "Zanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation and that someone needs to watch me closely for a period of 8 to 10 hrs.

I understand someone needs to watch me closely for a period of 8-10 hours, following my dental appointment, to observe possible delirious side effect, such as obstruction of airways. **(Initials)**_____

2. ORAL HYGIENE:

I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits. **(Initials)**_____

3. PERIODONTICS (TISSUE AND BONE LOSS):

I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

(Initials)_____

4. REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time.

Potential risks include, but are not limited to, the following:

A. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infection (requiring prescriptions or additional treatment, i.e., surgery.

B. Injury to adjacent teeth, caps, or fillings (requiring the recementation of crowns, replacement of fillings. fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area.

C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or temporomandibular joint (jaw joint) difficulty possibly requiring physical therapy or surgery).

D. Residual root fragments or bone spicules left when complete removal should require extensive surgery or needless surgical complications.

E. Possible bone fracture which may require wiring or surgical treatment.

F. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning sensation of the lip, chin, gums, cheek, teeth, and/or tongue or pain in the jaw on the operated side; this may persist for several weeks, months, or in remote instances, permanently.

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation. **(Initials)**_____

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever (s)he may deem advisable including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility. **(Initials)**_____

5. FILLINGS:

I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines and as such is a treatment used by Universal Care. The advantages and disadvantages of alternate materials. **(Initials)**_____

6. CROWN AND BRIDGE (CAPS):

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy. I further understand I may be wearing temporary crowns, which may come off easily and I must be careful to ensure that they be kept on until permanent crowns are delivered. I realize the final opportunity to make changes in my crown, bridge or cap (including shape, fit size, and color) will be before cementation.

I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleanings, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment. **(Initials)**_____

7. DENTURES - COMPLETE OR PARTIAL:

The problems of wearing dentures has been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. Persistent sore spots should be immediately examined by the doctor.

I further understand that surgical intervention (i.e. tori [bone] removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction.

(Initials)_____

8. ENDODONTIC TREATMENT (ROOT CANAL THERAPY):

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that treatment risks can include, but are not limited to the following:

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary.
B. Post treatment swelling of the gum area in the vicinity of the treatment tooth or facial swelling, may persist several days or longer.
C. Infection and/or restricted jaw opening.
D. Breakage of root canal instruments during treatment, which may in the judgment of the doctor be left in the treatment root canal as part of the filling material; or it may require surgery for removal.
E. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
F. Risk of temporary or permanent numbness in treatment area.

If an “open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss. If root canal therapy fails, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction. (**Initials)**_____

9. PEDIATRIC DENTAL CONSENT FORM:

I understand that the following procedures are routinely used at Universal Care Dental Services, as well as being accepted procedures in the dental profession.

A. Parent/guardian Cooperation - Unless the child if fully cooperative in the presence of the parent/guardian, the parent/guardian agrees to remain in the waiting room while the child is being treated.
B. Positive Reinforcement - Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.
C. Voice Control - The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
D. Hand-Over-Mouth Exercise - The disruptive child is told that a hand is to be placed over the child's mouth. When the hand is in place, the dentist speaks directly into the child's ear and tells the child that if the disruptive noise stops the hand will be removed. When the noise stops the hand is removed and the child is praised for cooperating. If the noise resumes the hand again is placed on the mouth and the exercise repeated. At no time is the airway ever restricted.
E. Physical Restraint - Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special device (referred to as a "papoose board").
F. Nitrous Oxide Analgesia and/or Oral Sedation - Nitrous Oxide is a mild gas that is mixed with oxygen, and used to sedate a person. It is administered through a breathing mask. Oral sedation medications are administered to children to help them relax. The child should not eat or drink for a period of four hours prior to the Nitrous Oxide sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe his/her behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bite his/her lip causing injury to occur. I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time. **(Initials)**_____

10. CHANGES IN TREATMENT PLAN:

I understand 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 the examination , the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to may any/all changes and additions necessary.

I understand that need to return to the dental office, for evaluation, if swelling and/or pain in my mouth do not go away after a sufficient period of time.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE COOPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

Print name of Patient/Legal Representative: _____ Relationship:_____ Date: _____

Signature of Patient/Legal Representative: _____ Date: _____

Doctor: _____Witness: _____ Date: _____