Nooshin Ghayoumi DDS, Inc
113 Waterworks Way Suite 255 Irvine,CA 92618

Patient Information

Date_____

First Name_____ Last Name _____ M_____ Preferred Name_____

Sex ( ) M ( ) F SSN _____ Driver's License_____ DOB_____

Address_____City_____ State_____ Zip Code_____

Home Phone (____)_____ Work Phone (____)_____Cell Phone (____)_____

Occupation_____Employer_____

E-mail_____Fax_____

Referred to our office by_____

Circle One: Minor Single Married Divorced Separated Other

Responsible Party Information (If Different from Info Above)

Name of Responsible Party _____ SSN _____

Address _____ City_____ State_____ Zip Code_____

Occupation_____ Employer_____

Employer's Address_____ City_____ State_____ Zip Code_____

Dental Insurance Information

Insurance Company_____ Subscriber First Name_____ Last Name_____

Insured DOB_____ Relationship to Patient_____ Employer_____

ID #_____ Group #_____ Phone #_____

Insurance Co. Address_____ City_____ State_____ Zip Code_____

Secondary Insurance

Insurance Company_____ Subscriber First Name_____ Last Name_____

Insured DOB_____ Relationship to Patient_____ Employer_____

ID #_____ Group #_____ Phone #_____

Insurance Co. Address_____ City_____ State_____ Zip Code_____

Patient Medical History

General Health: Good ( ) Fair ( ) Poor ( )

Physician Name_____ Office Phone_____ Date of Last Exam_____

Are you currently on any prescription or over the counter medications, vitamins or herbal supplements? **Yes ( ) No ( )**

If **"Yes"** please list medications and purpose:

_____ _____

_____ _____

Are you **allergic** to any medications? **Yes ( ) No ( )** If **"Yes"** please circle or list:

Penicillin Codeine Latex Local Anesthetics Sulfa Drugs Barbiturates Sedatives

Iodine Aspirin Any Metals Erythromycin Tetracycline Other

_____ _____

Please mark the ones that apply to you and your Medical History

( ) Need antibiotic coverage prior to dental work?

( ) Artificial joint replacement or Implant?

( ) Undergone Radiation or IV Chemotherapy?

( ) Use or have used tobacco products?

( ) Recently hospitalized or past major surgeries?

( ) Excessive thirst and/ or urination?

( ) Recent unusual weight loss?

( ) Subject to fainting?

( ) Subject to prolonged bleeding?

( ) Family history of Diabetes?

( ) {Woman} Currently pregnant? ( ) Y ( ) N Months? _____ Currently nursing? ( ) Y ( ) N

( ) Taking any Bisphosphonates (medications for Osteoporosis such as: Fosamax, Boniva)

Please circle **Y** or **N** individually for each question:

Y N High or Low Blood Pressure (Circle One)	**Y N** Heart Disease	**Y N** Osteoporosis
Y N Heart Attack	**Y N** Cardiac Pace Maker	**Y N** Chest Pains
Y N Rheumatic Fever	**Y N** Heart Murmur	**Y N** Swollen Ankles
Y N Long-Term Steroid Treatment	**Y N** Artificial Heart Valves	**Y N** Scarlet Fever
Y N Fainting/ Seizures	**Y N** Frequently Tired	**Y N** Tuberculosis
Y N Respiratory Problems	**Y N** Thyroid Problems	**Y N** Asthma

Y N Epilepsy/ Convulsions	**Y N** Emphysema	**Y N** Liver Disease
Y N Neck or Back problems	**Y N** Cancer (type :____)	**Y N** Kidney Disease
Y N Diabetes (type :____)	**Y N** Arthritis/ Rheumatism	**Y N** Glaucoma
Y N Jaundice/Hepatitis (type :____)	**Y N** Mitral Valve Prolapse	**Y N** Hemophilia
Y N AIDS/HIV Infection	**Y N** Sexually Transmitted Disease	**Y N** Anemia
Y N Alcohol /Drug Abuse	**Y N** Stomach Trouble/ Ulcers	**Y N** Leukemia

Do you have any other medical or health condition which is not listed? Yes ( ) No ( )

If **"Yes"** please list: _____

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

Dr. Signature: _____ ***Date:*** _____

Emergency Contact

First Name _____ Last Name_____

Relationship to You_____ Phone#_____

Address_____ City_____ State_____ Zip Code_____

Dental History

Name of Previous Dentist: _____ Last Dental Visit? _____

Reason for today's visit? _____

Have you ever had a serious problem associated with a previous dental treatment? **Yes ( ) No ( )**

If **"Yes"** explain_____

How often do you brush? _____ How often do you floss? _____ How often do you get cleanings? _____

Please answer Yes ( ) or No ( )

Are you hesitant to come to the Dentist?	**Yes ( ) No ( )**	Do you snore or have trouble sleeping?	**Yes ( ) No ( )**
Do your gums bleed during brushing or flossing?	**Yes ( ) No ( )**	Do you have loose dentures or partials?	**Yes ( ) No ( )**
Do you have missing teeth that you want replaced?	**Yes ( ) No ( )**	Do you still have your wisdom teeth?	**Yes ( ) No ( )**
Have you noticed any mouth odors or bad taste?	**Yes ( ) No ( )**	Are your teeth sensitive to heat/cold?	**Yes ( ) No ( )**

Consent for treatment

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I hereby authorize OCPI to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental conditions. I understand there are certain risks inherent in dental treatment; such as but not limited to: pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws, paresthesia and other procedure specific risk.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment on services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all costs of treatment.

Responsibility for payment: In the event that this matter is turned over to a collection agency or attorney for collection of any of these fees due herein; I hereby agree to pay all collection agency fees and all attorney fees, whether or not a lawsuit is instituted. I also acknowledge that I would be responsible for all court cost incurred in making collection sums due and unpaid for the work herein set forth.

Patient Name: _____

Signature: _____ Date: _____

Office Witness Initials: _____ Date: _____

Patient Hipaa Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 may be 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 have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 the address below 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 do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action replying to this consent.

Patient Name: _____

Signature: _____ **Date:** _____

***Notice of Privacy Practices*/ (Dental Non-Profit Version)**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

Dental Service Arbitration Agreement

Arbitration has becomes an increasingly common way to resolve legal differences. The advantages of arbitration over traditional lawsuits are that, generally, arbitration is less expensive and issues are resolved in less time. If a candidate wishes to pursue a dispute that has not been resolved by the appeal process detailed in the *Limited Right of Appeal for Examination Candidates* the candidate must use the procedure described in the following Agreement to Arbitrate.

Article I

It is understood that any dispute as to dental malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompletely rendered, will be determined by submission of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article II

Said agreement for arbitration as provided in Article I above shall apply to the dentist, agents, representatives and employees, successors in interest and staff dentist of the dentist and patient "whether or not minor" his heirs-at-law, personal representatives and any claim in tort, contract or otherwise the other of demand for arbitration of any controversy, the parties to the controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after notice has been given, the two arbitrators go selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time of the date of the notice of the selection of the neutral arbitrator. All notices or other papers required to be served shall be served by US MAIL.

Article III

The Dentist named above agrees only to provide such services as in her opinion are reasonable, necessary and appropriate. Should patient for reasons personal to him/herself refuse to accept the procedures, medicines or courses of treatment recommended by the dentist, and if the dentist believed that no professionally acceptable alternatives exists and after being so advised that patient still refuses to follow the recommended treatment or procedure, then the patient shall be given no further treatment and the dentist recommended treatment or procedure, then the patient shall be given no further treatment and the dentist shall have no further responsibility to provide services specified herein for the condition under treatment.

Article IV

This agreement may be terminated only if written notice is given by the patient within thirty (30) days from the date patient executes this agreement and is no such notice is given, the agreements herein concerning arbitration shall be binding and compulsory.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE AN ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. (See Article I of this contract).

Patient Name: _____

Signature: _____ **Date:** _____