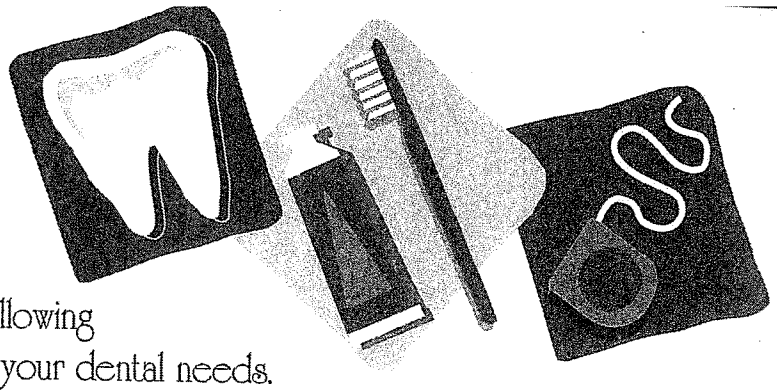
WELCOME
TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Latex	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐
- **Osteoporosis Medication** ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

Please list all new medications:

Please review Health History, Intial & Date:

DJAFARI D.D.S. INC. GENERAL DENTISTRY INFORMED CONSENT

OFFICE/PATIENT # ___ / _____ NAME _____

1. **TREATMENT TO BE DONE**:
I understand that I will be receiving an examination that includes a sufficient number of dental x-rays that may be necessary to complete my examination and any additional community appropriate diagnostic procedures that may be necessary to complete my dental examination and treatment plan. I also understand that if there was a need for a referral to a specialist deemed necessary by my Dentist, then the cost of this referral would be my responsibility. Initials _____

2. **DRUGS AND MEDICATIONS**:
I understand that antibiotics, analgesics and other medication can cause allergic reactions manifesting clinical symptoms such as redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock severe allergic reaction). I understand that it is my responsibility to inform my dentist of any allergy to specific medication to avoid possible adverse effects from medication that my dentist will prescribe. Initials _____

LOCAL ANESTHETICS: The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in the heart rate but will return to normal. Common complications that can occur from local anesthetic but are not limited to are pain, swelling, and bruising. Rare serious complications may occur that can include but are not limited to permanent numbness, abnormal sensation, transient blindness, and even death. Initials _____

3. **CHANGES IN TREATMENT PLAN**:
I understand that during treatment, it may be necessary to change or add procedures due to condition 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 once I have been informed of these changes and consented to them. I also understand that by not following my dentist's recommendation, delayed treatment can lead to but not limited to more discomfort, increase the complexity of the treatment outcome, or eventual lost of teeth. Initials _____

4. **EXTRACTIONS** REMOVAL OF TEETH)
I give my consent for the doctor to perform the extraction/surgery to treat and possibly correct my diseased oral tissue, or other procedures deemed necessary or advisable as necessary to complete the planned operation/extraction. If left untreated, the risks to my health may include, but are not limited to swelling, pain, infection, cyst formation, gum diseases, dental decay, malocclusion, premature loss of teeth and/or bone. My Dentist has informed me of possible alternative methods of treatment. Tooth #_____ Teeth #_____ _____ Initials _____

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

A. Post-operative discomfort; stretching of the corners of the mouth, with resultant cracking and bruising; 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, prosthesis, and/or restorations which may require additional treatment 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 tempromandibular joint jaw joint) difficulty possibly requiring physical therapy or surgery).
D. Residual root fragments or bones spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone, and/or jaw fracture, or opening of the maxillary sinus requiring additional surgery.
F. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue which may be temporary or permanent.

If any unforeseen condition should arise in the course of the operation/extraction, 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.

5. **CROWNS, BRIDGES, AND CAPS**:
I understand sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I may be wearing temporary crowns, which may come off easily and could be aspirated, and I must be careful to ensure that they are kept on until the permanent crowns are delivered. I understand that if my temporary crowns come off, then it is my responsibility to return to my dentist to have it re-cemented. I realize the final opportunity to make changes in my new crown, bridge, or cap including shape, fit, size, and color) will be before cementation. I understand if I do not return for my scheduled appointment for delivery of my crowns, or bridge, it may not fit properly, and I will be responsible for any lab fees. Tooth #_____ Shade _____ Initials _____

6. **DENTURES – COMPLETE OR PARTIAL**:
I realize full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand most dentures require relining approximately three to six months after initial placement and yearly thereafter. The cost for these relines is not included in the initial denture fee. I further understand that due to bone loss, lack of alveolar ridge support, muscle attachments and/or other complicating factors, I may never be able to wear dentures to my satisfaction.

Shade _____
Initials _____

7. **ENDODONTIC TREATMENT ROOT CANAL)**:
The purpose and method of root canal therapy have been explained to me as well as consequences of non-treatment and reasonable alternative treatments. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a final restoration usually a crown cap) over the tooth. I also understand that sometimes root canal therapy may fail and further treatment may be necessary that might include but not limited to retreatment, apicoectomy, or extraction.

Tooth #_____
Initials _____

I understand that treatment risks can include, but are not limited to the following:

A. Post treatment discomfort, infection, restricted jaw opening.
B. Swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
C. Separation of root canal instruments during treatment, which may in the judgment of the Dentist be left in the treated root canal or bone as part of the filling material; or it may require surgery for removal.
D. Perforation of the root canal which may require additional surgical treatment, or premature tooth loss extraction).
E. Risk of temporary or permanent numbness in treatment vicinity.
F. The root canal filling material may be overfilled or underfilled, which may or may not affect the success/outcome of the treatment.

8. **PERIODONTAL LOSS TISSUE & BONE)**:
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 and maintenance visits. I understand that I have a serious condition causing gum and bone inflammation and/or loss that can lead to loss of my teeth and other related systemic complications. The various treatment plans have been explained to me, including non-surgical scaling and root planning followed by local irrigation with oral medicaments and local delivery of antibiotic, or gum surgery, or replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. I understand that after following approved periodontal treatment there may still be a need for a referral to a Periodontist.

Initials _____

9. **FILLINGS:**
I have been advised of the need for fillings, either silver or composite plastic). 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 my recently placed fillings may cause some sensitivity and discomfort for duration and may be alleviated with time. However, I understand that if the symptom and sensitivity worsen, then I might need a RCT.

Initials _____

10. **PEDODONTICS** CHILDREN'S DENTRISTY)
I understand the following procedures are routinely used in conjunction with pediatric dentistry, as well as being accepted procedures in the dental profession. As the parent or authorized caregiver, I understand and give consent that the following procedures can be used on my child:

A. POSITIVE REINFORCEMENT- Rewarding the child who portrays desirable behavior, by use of compliments, verbal praises, or toys.
B. VOICE CONTROL- The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. PHYSICAL RESTRAINT- As the parent or authorized caregiver, I have been informed in advance and have given consent as it may be deemed necessary to restrain the child. 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").

I understand that with the use of local anesthetic for dental purposes, the possibility exists that the child may inadvertently bite their lip, tongue, and cheek causing injury to occur.

I understand that dentistry is not an exact science and that therefore, practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I have read and clearly understood the consent form language, and by signing below I acknowledge this understanding and give my consent to Dr. Djafari to perform the above indicated procedure(s). Dr. Djafari has encouraged me to ask questions. I have had the opportunity to ask questions and any and all of my questions have been answered to my satisfaction.

Signature: _____ Date: _____

Doctor: _____ Witness: _____

PARISSA DJAFARI, D.D.S.
6900 BROCKTON AVE., STE. 2
RIVERSIDE, CA 92506
(951) 682-2245

Notice of Privacy Practices
Patient Acknowledgement

Patient Name:_____ Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health Information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date:_____

Relationship to patient (if signed by a personal representative of patient):_____

Djafari D.D.S. Inc
6900 Brockton Ave Suite#2 Riverside CA, 92506 Office # (951)682-2245 Fax # (951)682-9169

PATIENT ACKNOWLEDGEMENT OF DENTAL MATERIALS FACT SHEET

I, _____, ACKNOWLEDGE THE DENTAL MATERIALS FACT SHEET IS AVAILABLE TO ME FOR REVIEW IN THE OFFICE OF DJAFARI D.D.S., INC.

PATIENT SIGNATURE_____ DATE_____

Djafari D.D.S. Inc.

6900 Brockton Ave Suite #2, Riverside Ca 92506 Office# (951)682-2245 Fax# (951)682-9169

Welcome To Our Office.

Our purpose in this office is to provide you with quality care and excellent dentistry. We treat each patient according to their specific needs. We allocate a certain amount of time for each procedure. However, some of our patients may require more time than others for various reasons (i.e. being apprehensive or having difficulty getting numb). We will not rush thru that; hence there may be a delay in the scheduled time. We appreciate your patience and understanding, knowing that we will do the same for you.

Also, because we have loyal and wonderful patients and everyone's time is very important Important to them, we would appreciate that in case you cannot make your scheduled Appointments you would give us a **48 Hour** notification so we can offer that time to another patient. If you miss an appointment without **48 Hour** notification there will be up to a **$75.00 charge** that will need to be paid prior to the time of your next appointment.

We are very happy to have you as a patient and we hope to serve you to the best of our capacity.

Sincerely,

_____

Dr Djafari.

Patient Signature _____ Date _____

Consent form:

I hereby authorize doctor(s) to take X-rays , study models, photographs, or any diagnostic aids deemed appropriate by Doctor(s) to make a thorough diagnosis of the patient's dental needs.

I also authorize Doctor to perform all forms of treatment, medication and therapy that may be indicated.

I also understand that the use of anesthetics embodies a risk factor.

I understand that Dentistry is not an exact Science, therefore reputable practitioners cannot properly guarantee results. I acknowledge that No guarantee or assurance has been made by anyone regarding the dental treatment that I have authorized. I understand that each Dentist is an individual Practitioner and is individually responsible for the dental care rendered to me.

Should any dispute arise over dental services provided to me , that is whether any dental services rendered was allegedly unnecessary , unauthorized or was improperly, negligently or incompetently performed, said dispute will be submitted to Peer Review by the local component of the American Dental Association. The Decision of the Peer Review shall be binding on both parties.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account and my dependents, for the services rendered. I agree to pay for any attorney fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I have read, understood and agreed to the above.

Signature:_____ Date: _____

Parent or guardian (if minor)

Doctor signature:_____ Date: _____