Torrance Dental Associates

Patient Name:____Date:______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Jealth problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes:____

Have you ever been hospitalized or had major operations? ◯Yes ◯ No If yes:_______________________________________

Have you ever had a serious neck or back injury? ◯ Yes ◯ No If yes:____

Are you taking any medications, pills or drugs? ◯ Yes ◯ No If yes:____

____

Do you take or have taken Phen Phen or Redux? ◯ Yes ◯ No If Yes:____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯yes ◯ No

If Yes: ____

Are you on a special diet? ◯ Yes ◯ No   Do you use Tobacco? ◯ Yes ◯ No

Women: Are you….

◯ Pregnant? ◯ Trying to get pregnant? ◯ Nursing? ◯ Taking oral contraceptives?

Are you allergic to any of the following?

◯Aspirin ◯ Penicillin ◯Codeine ◯Acrylic ◯ Metal ◯ Latex ◯Sulfas Drugs ◯ Local Anesthetics

◯ Other? ____

Do you use controlled substance? ◯ Yes ◯ No If yes:____

Do you have or had any of the following?

AIDS/HIV POSITIVE ◯Yes ◯No	Excessive Thirst ◯Yes ◯No	Mitral Valve Prolapse ◯Yes ◯No
Alzheimer's Disease ◯Yes ◯No	Fainting Spells/Dizziness ◯Yes ◯No	Osteoporosis ◯Yes ◯No
Anaphylaxis ◯Yes ◯No	Frequent Cough ◯Yes ◯No	Pain in Jaw Joints ◯Yes ◯No
Anemia ◯Yes ◯No	Frequent Diarrhea ◯Yes ◯No	Parathyroid Disease ◯Yes ◯No
Angina ◯Yes ◯No	Frequent Headache ◯Yes ◯No	Psychiatric Care ◯Yes ◯No
Arthritis/Gout ◯Yes ◯No	Genital Herpes ◯Yes ◯No	Radiation Treatment ◯Yes ◯No
Artificial Heart Valve ◯Yes ◯No	Glaucoma ◯Yes ◯No	Recent Weight Loss ◯Yes ◯No
Artificial Joint ◯Yes ◯No	Hay Fever ◯Yes ◯No	Renal Dialysis ◯Yes ◯No
Asthma ◯Yes ◯No	Heart Attack/Failure ◯Yes ◯No	Rheumatic Fever ◯Yes ◯No
Blood Disease ◯Yes ◯No	Heart Murmur ◯Yes ◯No	Scarlet Fever ◯Yes ◯No
Blood Transfusion ◯Yes ◯No	Heart Pacemaker ◯Yes ◯No	Shingles ◯Yes ◯No
Breathing Problems ◯Yes ◯No	Heart Trouble/Disease ◯Yes ◯No	Sickle Cell Disease ◯Yes ◯No
Bruise Easily ◯Yes ◯No	Hemophililia ◯Yes ◯No	Sinus Trouble ◯Yes ◯No
Cancer ◯Yes ◯No	Hepatitis A ◯Yes ◯No	Spina Bifida ◯Yes ◯No
Chemotherapy ◯Yes ◯No	Hepatatitis B or C ◯Yes ◯No	Stomach Disease ◯Yes ◯No
Chest Pains ◯Yes ◯No	Herpes ◯Yes ◯No	Intestinal Disease ◯Yes ◯No
Cold sores/Fever Blisters ◯Yes ◯No	High Blood Pressure ◯Yes ◯No	Stroke ◯Yes ◯No
Congenital Hearth Disorder ◯Yes ◯No	Cholesterol ◯Yes ◯No	Swelling of Limb ◯Yes ◯No
Convulsions ◯Yes ◯No	Hives or Rash ◯Yes ◯No	Thyroid Disease ◯Yes ◯No
Cortisone Medicine ◯Yes ◯No	Hypoclycemia ◯Yes ◯No	Tonsillitis ◯Yes ◯No
Diabetes ◯Yes ◯No	Irregular Heartbeat ◯Yes ◯No	Tubercolosis ◯Yes ◯No
Drug Addiction ◯Yes ◯No	Kidney Problems ◯Yes ◯No	Tumor or Growth ◯Yes ◯No
Easily Winded ◯Yes ◯No	Leukemia ◯Yes ◯No	Ulcers ◯Yes ◯No
Emphysema ◯Yes ◯No	Liver Disease ◯Yes ◯No	Veneral Disease ◯Yes ◯No
Epilepsy and Seizures ◯Yes ◯No	Low Blood Pressure ◯Yes ◯No	Yellow Jaundice ◯Yes ◯No
Excessive Bleeding ◯Yes ◯No	Lung Disease ◯Yes ◯No	

Have you ever had any serious illness not listed ◯Yes ◯No If yes:_______________________________________

Comments:____ **To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

Signature:____Date_________________________

TORRANCE DENTAL ASSOCIATES

New Patient Information Form

Patient____DOB ______________________

Parent Name (if minor) ____

Address ______________________________________City_________________________Zip___________

Patient or Parent employed by ___________________________Occupation ______________________

Social Security # ______-______-_____________Driver License/ ID# ______________________________

Phone: Home (_____)________________ Cell (_____)________________________

Email ____

Reason for your visit today ____

How did you hear about this office? ____

Please List any family members that are patients of this practice ________________________________

Person to contact in case of emergency _________________________phone (_____)_______________

Treatment and Arbitration Agreement

With the regard to dental care and services provided or to be provided at Torrance Dental Associates, it is agreed that the attending dentists will provide dental care and services to the patient, to the best of their skill and knowledge which dental care in the light of circumstances is possible and practical. It is agrees that because of differences in human constitution and response, it is in no way possible to warrant the outcome of any medical or dental service.

It is understood that any dispute as to dental malpractice, that is as to whether any dental service 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 of arbitration proceedings. Both parties to this contract, by entering into it are giving 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. Within fifteen days after a patient or attending dentist shall give notice to the other demanding arbitration of such controversy, the parties to the controversy shall each appoint a licensed dentist as arbitrator and give notice of such appointment to the other, within a reasonable time the two arbitrators shall select a licensed dentist as neutral arbitrator and give notice to the selection thereof to the parties. The arbitrator shall hold a hearing within a reasonable time. All notices or other papers required to be served shall be the California Code of Civil Procedure.

Notice: By signing this contract you are agreeing to have any issue of dental malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial.

Signature: ____ Date:____________________

Assignment of Insurance Benefits

I hereby authorize Alireza Movassaghi, DDS and/or Torrance Dental Associates to furnish information to insurance carriers concerning treatment and hereby assign to the doctors all payment for dental services rendered. This assignment will remain in effect until revoked by me in writing; a photocopy of this assignment is as valid as the original. ***I understand that I am financially responsible for all charges whether or not paid by said Insurance/ Dental Plan.*** I hereby authorize said assignee to release all information necessary to secure payment.

Signature: ____ Date:__________________

Torrance Dental Associates

Financial Understanding Form for Broken Appointments

Dear Patient,

In order to render quality care for your dental needs, we have to commit the doctor's time for you. ***Please take only those appointments which you can keep.***

Should you break your appointment without at least a **24-Hour Notice**, we will be unable to appoint another patient in your place. In this case, there will be a $50.00 fee for the broken appointment. For Monday appointments, please call on the Friday before.

Thank You for your anticipated cooperation!

I ________________________, have read and understood all of the following:

- **Treatment and Arbitration Agreement**
- **Assignment of Insurance Benefits**
- **Financial Understanding Form For Broken Appointments**

Signature: ____ Date:__________________

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of, Alireza Movassaghi, Notice of Privacy Practices*

Patient name:_______________________________________

Signature:____ Date:____________________

See Notice of Privacy Practices