



## **WELCOME TO OUR OFFICE!**

We would like to thank you for trusting our office to take care of your dental health. Here are some facts and information about our office. Please review this information and feel free to call us if you have any questions. Enclosed please find the health and dental questionnaire forms. Please complete them as accurately as possible. Also in compliance with HIPPA and OSHA laws we ask you to please read and sign the enclosed forms.

### **ABOUT DR. ARBAB**

Dr. Roya Arbab earned her bachelor degree in Biology from UCLA in 1985 and her Doctorate in Dentistry from USC in 1989. She earned her specialty degree in Prosthodontics from USC in 1991. Prosthodontics is an American Dental Association recognized specialty which focuses on cosmetic and aesthetic rehabilitation of dentition. Common prostheses include natural-appearing crowns, veneers, implants and dentures. She has been in private practice since 1991. She has also been an Associate Professor at the USC School of Dentistry.

### **FEES**

All payments are due at time of service.

### **INSURANCE**

Dr. Arbab has no affiliation with insurance companies, except for Delta Dental Premiere. However as a courtesy to our patients, our office will submit claims to all other insurance companies, with payments made directly to the patient. Patients will be reimbursed by their insurance company according to individual policy.

### **APPOINTMENTS**

Please note that we value appointment times. If you are unable to keep your appointment, as a courtesy to our other patients and staff, we ask that you inform us at least two(2) business days in advance of your reserved time. Missed appointments or cancellations with less than two(2) business days notice will result in a \$50.00 fee.



**Patient Information**

Date: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

E-mail \_\_\_\_\_

Sex \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Other \_\_\_\_\_

Spouse/Parent's Name \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Responsible Party**

Name Responsible for Account \_\_\_\_\_ Relation to patient \_\_\_\_\_

Address \_\_\_\_\_

DOB \_\_\_\_\_ Driver's License \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work phone \_\_\_\_\_

**Insurance Information**

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

SSN/Member ID# \_\_\_\_\_ DOB \_\_\_\_\_

Insurance company \_\_\_\_\_ Group# \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Employer address \_\_\_\_\_



## DENTAL HISTORY

How would you rate the condition of your mouth? Excellent \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_

Previous dentist \_\_\_\_\_ City, State \_\_\_\_\_

Date of last dental care \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

What is your immediate concern? \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

|   |     |    |
|---|-----|----|
| Have you ever been disappointed by previous dental work?                            | Yes | No |
| Is there anything about the appearance of your teeth that you would like to change? | Yes | No |
| Have you ever whitened (bleached) your teeth?                                       | Yes | No |
| Have you ever had braces, orthodontic treatment, or your bite adjusted?             | Yes | No |
| Have you had any teeth removed?   | Yes | No |
| Have you ever had trouble getting numb or reactions to local anesthetic?            | Yes | No |
| Do you have a dry mouth?  | Yes | No |
| Do you have problems chewing gum?   | Yes | No |
| Do you have problems chewing hard foods?  | Yes | No |
| Have your teeth changed in the last 5 years, become shorter, thinner or worn?       | Yes | No |
| Are your teeth crowding or developing spaces?                                       | Yes | No |
| Do you have more than one bite or do you clench to make your teeth fit together?    | Yes | No |
| Do you have problems with your jaw (pain, sounds, opening, locking, popping)?       | Yes | No |
| Do you have tension headaches or sore teeth?  | Yes | No |
| Do you wear or have you ever worn a bite appliance?                                 | Yes | No |
| Have you had any cavities in the past 3 years?                                      | Yes | No |

**Please circle** if you have had problems with any of the following:

- |                       |                       |                               |
|-----------------------|-----------------------|-------------------------------|
| Bad breath            | Bleeding gums         | Loose teeth                   |
| Sensitivity to sweets | Broken fillings/teeth | Sores or growths in mouth     |
| Sensitivity to hot    | Grinding teeth        | Food collection between teeth |
| Sensitivity to cold   | Periodontal treatment | Sensitivity to biting/chewing |

### Authorization and Release

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Arbab and staff if there any changes in my health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print above name

**MEDICAL HEALTH QUESTIONNAIRE**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Please circle Yes or No as applies to you:

|                                     |        |                                 |        |
|-------------------------------------|--------|---------------------------------|--------|
| High Blood Pressure/Hypertension    | Yes No | Anemia                          | Yes No |
| Heart Murmur                        | Yes No | Cancer                          | Yes No |
| Functional or nonfunctional?        |        | If yes, what type?              |        |
| Rheumatic fever                     | Yes No | Kidney disease                  | Yes No |
| Mitral valve prolapse               | Yes No | Radiation therapy               | Yes No |
| If yes, with regurgitation or not?  |        | Date:                           |        |
| Angina/chest pain                   | Yes No | Organ/cell transplant           | Yes No |
| Heart attack(myocardial infarction) | Yes No | Bleeding disorder               | Yes No |
| Prosthetic heart valve              | Yes No | Renal dialysis                  | Yes No |
| Hepatitis                           | Yes No | Chemotherapy                    | Yes No |
| Type:                               |        | Date:                           |        |
| Pacemaker/defibrillator             | Yes No | Epilepsy/seizure                | Yes No |
| Congestive heart failure            | Yes No | Stomach/intestinal disorder     | Yes No |
| Stroke/TIA                          | Yes No | Arthritis                       | Yes No |
| Emphysema/bronchitis                | Yes No | Irregular heartbeat(arrhythmia) | Yes No |
| Asthma                              | Yes No | Sexually transmitted disease    | Yes No |
| Diabetes mellitus                   | Yes No | Artificial joint                | Yes No |
| Type:                               |        | Date:                           |        |
| Thyroid disorder                    | Yes No | Tuberculosis                    | Yes No |
| Autoimmune disorder                 | Yes No | Psychiatric disorder            | Yes No |
| Liver disease                       | Yes No | Allergies                       | Yes No |
| HIV/AIDS                            | Yes No | Pregnant                        | Yes No |



|  |  |     |    |
|--|--|-----|----|
| Do you have any shortness of breath?   |  | Yes | No |
| Do you have any shortness of breath while lying down?  |  | Yes | No |
| Do you have swollen ankles?  |  | Yes | No |
| Do you experience frequent urination and/or thirst?  |  | Yes | No |
| Do you have excessive hunger?  |  | Yes | No |
| Do you have heat intolerance?  |  | Yes | No |
| Do you bruise easily?  |  | Yes | No |
| Do you have spontaneous nose bleeding?   |  | Yes | No |
| Do you experience difficulties with coordination?  |  | Yes | No |
| Have you ever taken medications with biphosphonates?<br>(e.g. Fosamax, Boniva, Actonel, Reclast) |  | Yes | No |
| Are you allergic to latex?   |  | Yes | No |
|  |  |     |    |
|  |  |     |    |

List medications you are currently taking and associated diagnosis:

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List allergies:

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Roya Arbab DDS may use my health care information and may disclose such information to my insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Print Above Name

\_\_\_\_\_  
Relationship to Patient



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Additional Specific Risks:

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I certify that I have read and understand this **INFORMED CONSENT** which outlines the general treatment considerations as well as the potential problems and complications of restorative/prosthetic treatment. I understand that potential complications and problems may include, but are not limited, to those described in this document. I have been given the opportunity to ask questions about the proposed treatment and the risks, as well as the potential consequences should I elect to postpone or refuse treatment. I understand that during and following treatment, conditions may arise that warrant additional or alternative treatment. I further understand that no guarantees can be made for a successful result.

Recognizing the potential problems and risks of restorative/prosthetic treatment, authorization is given for dental treatment to be rendered by the dentist and office staff. In addition, I grant permission for photographs taken by Dr. Roya Arbab, or photographs released from other healthcare practitioners, of the procedures to be publicized for teaching purposes only.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_





## **FINANCIAL ACKNOWLEDGMENT AND RELEASE**

**Policy** - Payment is due in full at time of service unless prior arrangements have been approved.

### **Insurance**

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We are not preferred providers or members or have any association with any insurance organizations except Delta Dental Premiere. The dentist's treatment recommendations or fees are not affected or influenced by insurance status. Treatment recommendations are based solely on your dental needs and/or desires. Dental benefits are a contract between you the patient, the employer, and insurance company. Any acquisition of insurance benefit information done by the office is done as a courtesy to the patient. We will also prepare and submit claims to assist you in obtaining maximum benefits available to make your dental experience as smooth as possible. However, you the patient are responsible for all fees incurred, regardless of insurance coverage. You may at any time choose to handle your dental claims personally.

### **Collections**

In the event your account balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed below agrees to pay interest, collection and other legal expenses related to collection of fees owed.

\_\_\_\_\_  
Responsible Party (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## **RESTORATIVE AND HYGIENE APPOINTMENTS**

### **Cancellation/ Rescheduling**

We ask for at least **two (2) business days** advance notice for canceling or rescheduling an appointment. Otherwise, a **\$50** fee *will* be assessed to your account. All Monday appointments need to be changed by the previous Thursday 11:30a.m. Overnight/weekend phone messages will not suffice as cancellations.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people--the patient who missed the valuable time, the other patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment.

Note: All cancellation fees must be paid prior to scheduling another appointment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

