WELCOME TO SINCERE SMILES, DENTAL PRACTICE OF DR. FATIMA VAFAI DDS, INC

Patient Information

First Name:_____ Middle Initial:____ Last Name:_____Preferred Name:_____

Gender:◯Male ◯ Female Date of Birth: _____ (mm/dd/yyyy)

SSN#:_____ Driver's License#:_____

Phone Numbers: Home: _____ Work: _____ Ext:_____ Cell: _____

Email: _____

Home Address: _____

City: _____ State: _____ Zip code: _____

Are you a student? ◯Yes ◯No If Yes, Name of School: _____

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Minor

If Minor, Name of responsible guardian: _____ Relationship to patient: _____

In case of emergency contact name: _____ Phone number: _____

Occupation: _____ Employer: _____

Employer Address: _____

Whom may we thank for referring you to our office? _____

Insurance Information

Primary

Name of Insured: _____ Patient relationship to insured: ◯Self ◯Spouse ◯Child ◯Parent

Insured Birth Date: _____ Insured social security# (or ID#): _____

Insured Employer Name: _____

Employer Phone#: _____ Group#:_____

Insurance plan name & Address: _____

Insurance co. phone#: _____

Secondary

Name of Insured: _____ Patient relationship to insured: ◯Self ◯Spouse ◯Child ◯Parent

Insured Birth Date: _____ Insured social security# (or ID#): _____

Insured Employer Name: _____

Employer Phone#: _____ Group#:_____

Insurance plan name & Address: _____

Insurance co. phone#: _____

Medical History

1) Do you have or ever had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS/HIV Infection	◯	◯	Headaches (frequently)	◯	◯	Rheumatic Fever	◯	◯
Alcohol Dependency	◯	◯	Heart Attack Date: _____	◯	◯	Sexually Transmitted Disease	◯	◯
Anemia	◯	◯	Heart Disease	◯	◯	Shortness of Breath	◯	◯
Angina/Chest Pain	◯	◯	Heart Murmur	◯	◯	Sinus Problems	◯	◯
Arthritis/ Rheumatism	◯	◯	Hemophilia	◯	◯	Stomach Problems/ Ulcers	◯	◯
Asthma	◯	◯	Hepatitis (Type: _____)	◯	◯	Stroke Date:_____	◯	◯
Blood Disease	◯	◯	High Blood Pressure	◯	◯	Thyroid Disease	◯	◯
Blood Transfusion	◯	◯	Joint/hip Replacement Date: _____	◯	◯	Tuberculosis	◯	◯
Cancer	◯	◯	Kidney Disease	◯	◯	Tumors	◯	◯
Chemical Dependency	◯	◯	Liver Disease	◯	◯	Other: _____		
Chemotherapy	◯	◯	Mental Disorders	◯	◯			
Cortisone Treatment	◯	◯	Mitral Valve Prolapse	◯	◯			
Diabetes	◯	◯	Pacemaker	◯	◯			
Epilepsy	◯	◯	Prosthetic Heart Valve	◯	◯			
Glaucoma	◯	◯	Radiation Treatment	◯	◯			
Hay Fever/Allergies	◯	◯	Respiratory Disease	◯	◯			

2) Are you allergic to or have you had any reactions to the following?

☐ Aspirin
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic (e.g. Novocain)
☐ Metals (e.g. nickel, mercury,etc.)
☐ Nitrous
☐ Penicillin
☐ Sulfa Drugs
☐ Tetracycline
☐ I Do Not Have Any Known Allergies
☐ Other (please list): _____

3) Are you taking any medication(s) including non-prescription drugs? ◯ Yes ◯ No

If yes, please list medications /supplements: _____

4) Date of last physical exam:_____(mm/yyyy) Physician's Name: _____

Office Phone#: _____

5) Are you under medical treatment now? ◯ Yes ◯ No

If yes, please explain: _____

6) Have you been hospitalized for any surgical operation or serious illness during the past five years? ◯ Yes ◯ No

If yes, please explain: _____

7) Do you use tobacco? ◯ Yes ◯ No

8) Have you ever taken Fen-Phen/Redux? ◯ Yes ◯ No

9) Do you or have you taken Bisphosphonates (e.g. Fosamax, Actonel, etc.)? ◯ Yes ◯ No

10) Women Only:

Are you pregnant or think you may be pregnant? ◯ Yes ◯ No Due Date: _____ (mm/dd/yyyy)

Are you nursing? ◯ Yes ◯ No

Are you taking oral contraceptives? ◯ Yes ◯ No

Dental History

When was your last dental visit? _____ (mm/dd/yyyy) Former Dentist: _____ Phone#:_____

Why are you here today? _____

Do you like your smile? ◯ Yes ◯ No

If you could, what would you change about your smile? _____

Please check any of the following that may apply to your dental health:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clenching or Grinding
- ☐ Clicking or Popping Jaw
- ☐ Dentures or Partials (false teeth) If so, how old are they? ____
- ☐ Difficulty in opening or closing jaw
- ☐ Excessive daytime sleepiness
- ☐ Frequent Headaches
- ☐ Obstructive sleep apnea
- ☐ Orthodontics (braces) If so, when? _____ (mm/dd/yyyy)
- ☐ Receding Gums
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Sweets
- ☐ Sensitivity to Bite
- ☐ Snoring
- ☐ Sores or Lumps in or near your mouth
- ☐ Trouble sleeping or staying asleep
- ☐ Other: _____

Have you ever had unusual reactions to dental treatments? ◯ Yes ◯ No

If yes, please explain: _____

Surveillance

I understand this premises is under surveillance.

Patient or Guardian Initials: _____

Consent for Services

I certify that I have read and understand the above. The above answers and information provided are true and correct. I understand that providing incorrect information can be harmful to my health. If I ever have any change in my health, I will inform the doctors at the next appointment. Radiographs in conjunction with a clinical exam are necessary for a thorough and accurate diagnosis and dental treatment plan. Examination radiographs are generally taken once a year for adults and every six months for children. However, the frequency at which radiographs are taken will be based upon individual dental need. I authorize and consent the dentist to perform any and all forms of treatment including diagnostic aids, photos and radiographs, medication and therapy that may be indicated in connection with the patient as s/he deems fit. I authorize and request my insurance company to pay directly to Sincere Smiles otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependent. I authorize Sincere Smiles to release my medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists' providers which are assigned to me according to my insurance policy rule. It is Sincere Smiles procedure to share protected health information with labs, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary protected health information.

Patient or Guardian Initials: _____

Financial Policy

Financial & Insurance Policies:

At Sincere Smiles our goal is to provide our patients with leading edge dental technologies, the finest dental materials, and expert staff in a comfortable environment. In order to provide this quality of dental care, we request all of our patients pay their estimated personal cost of treatment (estimated co-pay, deductible, laboratory fees...) at the time of their visit. As a courtesy to our patients, we will file your dental claims and bill your dental insurance company(s) for treatments you receive. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

A service charge of 1 ½ % (18% annual) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Any accounts past due over 90 days may be sent to a collection agency. The fee estimate listed for dental care can only be extended for a period of three months from the date of patient examination.

Office Cancellation/Missed Appointment Policy:

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved exclusively for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 48 hours notice (two business days) if you need to reschedule your appointment. We reserve the right to charge patients who do not reschedule their appointments with adequate notice, or who fail to keep their scheduled appointments, an appropriate cancellation fee ($75/hour).

I have read the above policies and agree to their content.

Patient or Guardian Initials: _____

DMFS & HIPAA

Proposition 65 M Dental Materials Fact Sheet (DMFS)

The state of CA, under the proposition 65, now requires each dentist to give each of their patients a copy of their information relating to the matters and techniques used in the dental environment. This information is contained in the attached document entitled “DENTAL MATERIAL FACT SHEET”. It is required that all patients sign they have received a copy of this document. If you have any questions regarding information contained within the document, please feel free to bring your questions to our attention.

I acknowledge that I have received a copy of the DMFS required by law.

Patient or Guardian Initials: _____

Notice of Privacy Practices (HIPAA)

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.

I acknowledge that I have received a copy of the HIPAA privacy practices.

Patient or Guardian Initials: _____