Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

Barranca Canyon Dentistry • 15785 Laguna Canyon Rd, suite 270 • Irvine, CA 92618• (949) 654-4654

PATIENT INFORMATION

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Other: _____
First MI Last

Address _____ City _____ State _____ Zip _____

Hm#(___)_____ Cell#(___)_____ Occupation: _____

Employer _____ Wk# (___)_____Ext _____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Gender: [ ]Male [ ]Female

DOB: ____/_____/_____SSN# _____ E-mail _____@_____

Spouse's Name _____
First MI Last

Spouse occupation _____ Spouse's Phone# _____

Is patient a full time student? [ ] No [ ] Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Hm# (___)_____

Cell# (___)_____

DOB: ____/_____/_____

SSN# _____

Relationship to patient: _____

YOUR PREFERENCES

Do you prefer appointment reminders by:
[ ] Email [ ] Phone [ ] Text

Do you prefer to receive calls from our office at:
[ ] Home [ ] Work [ ] Cell

Whom may we thank for referring you?

_____

How do you wish to be addressed by our staff?

_____

INSURANCE INFORMATION

***SUPPLEMENTAL INSURANCE (DENTAL INSURANCE):**

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

*DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____SSN# _____ Employer: _____

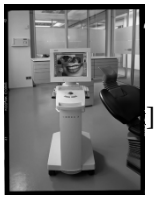
Insurance Company _____ Group # _____ Eff. Date: ___/___/____

***MEDICAL INSURANCE:**

Subscriber's Name _____ Relationship to patient: _____

DOB: _____/_____/_____ Subscriber's SSN# _____

Insurance Company _____ Policy # _____ Group #_____



Our practice is one of the most advanced CAD/CAM practices in the US. We use 3-D CEREC technology to produce ceramic restorations in a single visit.

CONFIDENTIAL

MEDICAL HISTORY and CONSENT

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

Allergies

Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Acrylics	Y	N
Metal	Y	N
Sulpha	Y	N
Anaphylaxis	Y	N
Other allergies	Y	N

List other known allergies:

_____

_____

Oral

Tooth pain	Y	N
Bleeding gums	Y	N
Dry mouth	Y	N
Jaw problems (TMJ)?	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty swallowing?	Y	N
Difficulty chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontal (gum)Disease	Y	N
Teeth clenching	Y	N
Teeth grinding	Y	N
Tooth pain	Y	N
Wisdom teeth extraction	Y	N
Use oral appliance/guard	Y	N
Do you take or need antibiotics before dental procedures?	Y	N

Social History

Do you smoke? Y N

_____ packs a day

Do you use smokeless tobacco? Y N

Do you consume alcoholic beverages?

_____Drinks per day/week/month

Do you use recreational drugs? Y N

Sleep

Daytime Sleepiness	Y	N
Morning headaches	Y	N
Has anyone told you that you snore?	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N

How often? _____

General

Current weight: _____lbs

Height: _____ ft _____in

Are you Pregnant	Y	N
Are you Breast feeding	Y	N
Cancer	Y	N

If yes, explain, _____

General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/hip replacement	Y	N
Liver problems	Y	N
Kidney disease	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Recent Weight Change	Y	N

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Thyroid problems	Y	N
Hormonal Change	Y	N

Eyes, Ears, Nose and Throat

Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus (Ringing)	Y	N
Hearing Aide	Y	N
Impaired Vision	Y	N

Glasses[ ] Contacts[ ]

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

Hematological

Bleeding problems	Y	N
Hepatitis	Y	N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating disorders	Y	N
Excessive Stress	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea(shortness of breath)	Y	N
Emphysema	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

MEDICAL HISTORY and CONSENT

List any medications you are taking:

Medication	Dosage/Freq.	Prescriber	Reason
1.			
2.			
3.			
4.			

List any surgeries or hospitalizations you have had:

Date(year)	Surgery/Location	Reason
1.		
2.		
3.		
4.		

Do you take or have you ever taken Fosamax Yes No

List and detail any medical condition or history not listed previously:

_____

_____

_____

Primary Physician's Name: _____ Physician's phone #: _____

Are you under the care of other physicians? If so, please list:

Physician Phone # Reason

_____

_____

_____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Samira Shafaee DDS and Shahram Shahriyarpour DDS and all staff at Barranca Canyon Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Samira Shafaee DDS and Shahram Shahriyarpour DDS to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that they choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 1/2% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Barranca Canyon Dentistry to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to Barranca Canyon Dentistry, and to handle any necessary claim appeal(s) on my behalf.

Office Policy:
There is a charge of $75 for Hygiene and $100 for Doctor's appointments cancelled with less than 24 hours notice.

Consent - (adult)

Name of Patient _____ _____ **Date** _____
Signature of Patient

Consent for a minor child:
Name of Parent/Guardian _____ _____ **Date** _____
Signature of Parent/Guardian

Doctor: _____ **Date:** _____
Treating doctor's signature

Notice of Privacy Practices (below)

Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information. By signing below you are acknowledging receiving notice of our practices' policies.

I allow release of pertinent medical records to my insurance company (if applicable) and my other medical providers.

_____ **Date** _____
Signature of Patient