17931 MacArthur Blvd. Irvine, CA 92614
Tel: (949) 862-0028 Fax: (949)862-0038
Web: www.ocsmiledental.com

O.C. Smile Dental

Practice of Basem Airood DDS, Inc.

Chart #:_____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

(Cell): _____ E-mail: _____ Driver's Lice. #: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ **Is insured a patient?** ☐ **Yes** ☐ **No**
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:**_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

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.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

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HEALTH HISTORY

PATIENT NAME: _____ DATE: ____/____/____

DATE OF BIRTH: ____/____/____ SEX: M / F HEIGHT: FT. ____ IN.____ WEIGHT: _____

We protect the privacy of each of our patients. And our office meets or exceeds the latest state and federal infection control requirements.

INSTRUCTIONS:

Answer all questions and fill in the blank spaces where indicate. Answers to the following questions are for our records and will be kept confidential. The information you provide us is used to assure maintenance of your overall well being.

Why are you here today? _____

When was your last visit to a dental office? _____

When were your last dental x-rays taken? _____

	YES	NO
1. Are you in poor health?		
2. Has there been any changes in your general health Within the past year		
3. My last physical exam was on ____/____/____		
4. Are you now under the care of a physician?		
5. The name, address and phone number of my primary care Physician is? _____		
6. Have you had any serious illness or operation? If so, please explain. _____		
7. Do you have or have you had any of the following ?		
A. Congenital heart lesions or murmurs?		
B. Cardiovascular disease (irregular heartbeat, heart attack, angina, High blood pressure, vascular problem or stroke)...		
* Do you have chest pain upon exertion?		
* Are you ever short of breath after mild exercise?		
* Do your ankles swell?		
* Do you get short of breath when you lay down?		
* Do you have a cardiac pacemaker?		

C. Sinus problems? _____ _____
D. Asthma? _____ _____
E. Hives or skin rash? _____ _____
F. Fainting spells or seizures? _____ _____
G. Diabetes? _____ _____
H. Hepatitis, jaundice or liver disease? _____ _____
I. Arthritis? _____ _____
J. Connective tissue disease? _____ _____
K. Stomach ulcers? _____ _____
L. Kidney problems? _____ _____
M. Tuberculosis, Lung problems? _____ _____
N. Low blood pressure? _____ _____
O. Venereal disease? _____ _____
P. Do you have prosthetic hip or joint, implants, bone plates or screws? _____ _____
Q. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? _____ _____
R. Are you taking any drugs or medication? _____ _____
If so what? _____
_____
S. Do you have any allergies? _____ _____
If so what? _____
T. Are you allergic to Latex? _____ _____
U. Have you had any serious troubles related to previous dental work? _____ _____
V. Have you ever had any of the following conditions? _____ _____
A. Herpes C. Hepatitis
B. HIV/AIDS D. Tuberculosis
W. Does your bite feel off? _____ _____
X. TMJ Pain or noise? _____ _____
Y. Clinching/Grinding? _____ _____

Women

1. Are you pregnant? _____ _____
2. Are you nursing? _____ _____
3. Are you on any form of birth control? _____ _____

FOLLOW UP TO MEDICAL HISTORY BY DENTIST ONLY _____

I have filled out this Health Questionnaire completely. I have advised you of all medical problems of which I am aware of. I hereby certify that I have read the foregoing. I further certify that, I the undersigned, consent to the performing of x-rays, examination and whatever dental treatment may be agreed upon to be necessary or advisable.

PATIENT SIGNATURE: X_____ **DATE:** ___/___/___

SIGNATURE OF DENTIST: X_____ **DATE:** ___/___/___

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Patient Consent To Treatment

In reading and signing this form it is understood that ENGLISH is the language that I understood and use to communicate.

(Initials)_____ Examination:

Radiographic (x-rays) _____ visual: _____

1. DRUGS, MEDICATIONS, AND ANESTHESIA

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but not limited to, redness and swelling of tissue, pain, itching, vomiting, dizziness, miscarriage, and cardiac arrest.

I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, not operate any vehicle or hazardous device while taking medications and/or drugs, or until I fully recover from the effects (this includes a period of at least twenty-four (24) hours after my release from surgery. I understand if select to utilize Diazepam, Xanax, or any other sedative, possible risk included, but are not limited to loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest. I understand that someone needs to be with me at the dental office after, I have received sedation. I also understand that someone must watch me closely for a period of 8-10hrs, following my appointment, to observe possible effects, such as obstruction of airways.

(Initials) _____

2. HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long-term success of treatment and status of my oral condition depends on my proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits, every 3,4, or 6 months as indicated by Dr. Basem Airood.

(Initials) _____

3. PERIODONTICS:

I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and it can be led to loss of my teeth and other complications. The various treatment plans have been explained to me, such as SOFT TISSUE MANAGEMENT- HIGH GUM TREATMENT, AND LASER ASSISTED PERIODONTAL THERAPY including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed, occasionally, treated teeth may require extraction.

(Initials) _____

4. REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly, correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time.

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

A. Postoperative discomfort: 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, caps, or filings (requiring the re-cementation of crowns, replacements of fillings, fabrications of crowns, or extractions), 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 temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery).
D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.
E. Possible bone fracture which may require wiring or surgical treatment.
F. Opening of the sinus (a normal cavity situated above the upper teeth) requires additional surgery.
G. Injury to the nerves underlying the teeth resulting in itching numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operate side, this may persist for several weeks, months, or in remote instance permanently..

(Initials) _____

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or for other procedures deemed necessary or advisable as necessary to complete "the planned operation".

If an unforeseen condition should arise in the course of operation, calling for the doctors judgment or for procedures in addition to/ or different from now contemplated.

(Initials)_____

5. FILLINGS:

I have been advised to the need for fillings, either silver, resin restorations (tooth colored), or composite to replace tooth structure lost to decay. I understand that with time fillings need to be replaced due to wearing of material. In cases where little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment, which necessitates a separate charge.

(Initials) _____

5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY):

The purpose and method of root canal therapy have been explained to me as well as reasonable alternative treatment and consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by replacement of a crown (cap) over the tooth.

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

A. Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may, persist for several days.
C. Infection
D. Restricted jaw, openings
E. Breakage of root canal instruments during treatment, which may in the judgment of the doctor be left in the treated root canal or bone as part of the filling material, or it may require surgery for removal.
F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.

If an open and medicate or pulpotomy procedures is preformed, I understand that this is not permanent treatment and I need to pay for, and finish root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss.

If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required or the tooth may have to be extracted.

(Initials)_____

6. CROWN AND BRIDGE (CAP)

I understand that sometimes is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating root canal therapy.

I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleaning, otherwise decay may develop underneath and/or around the margins of the restoration, leading to further dental treatment.

(Initials)_____

7. DENTURES COMPLETE OR PARTIAL:

The problem of wearing dentures has been explained to me including looseness, soreness, and possible breakage, and relining due to the issue change. Follow up appointments are an integral part of maintenance and success of a prosthetic appliance persistent sore spots should be immediately examined by the doctor. I further understand that surgical intervention removal, bone re-countering, or implants may be needed for dentures to be properly fit. I also understand that due to the bone loss or other complicating factors, I may never be able to wear dentures to my satisfaction. **(Initials)** _____

I UNDERSTAND THAT NOT GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE, RELIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTI-MUM RESULTS. I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS AND HAVE HAD THEM ANSWERED TO MY SATISFACTION. I UNDERSTAND THAT DR. AIROOD AND STAFF AT O.C. SMILE DENTAL PROVIDES HIGH QUALITY DENTAL CARE SERVICES AND ENFORCES AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS.

PATIENTS SIGNATURE: _____ **DATE:** _____

DENTISTS SIGNATURE: _____ **DATE:** _____