Welcome to Safe Dental Care

Thank you for selecting our dental health care team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out these forms completely in ink. If you have any questions or need assistance, please ask us; we will be happy to help. *Sincerely, Safe Dental Care Inc.*

Patient Information (Confidential)

Name (Last) _____ *(m)* ____ *(First)* _____ *Birthday*__/__/__ *Social. Security #*___-___-____

Please Circle appropriate one: //.Male Female //.../ / Minor Single Married Widowed Divorced //

*Address (Home):*_____ *City* _____ *State* _____ *Zip Code* _____

Phones; *Home*_____ *Cell*_____ *Work* _____ *Other*_____

*Patients or parents employer*_____ *Phone ;(_ _ _) _ _ _ _ Business Address:* _____ *City* _____ *State* __ *Zip Code*___

Spouse or parent's name, _____ *Employer*_____ *Phone,* _____

If patient is a student, name of school / college _____ *City*_____ *State*_____

Whom may we thank for referring you? _____.*Person to contact in case of emergency* _____ *Phone (_ _ _) _ _ _ _*

Responsible party

Name of person responsible for this account: _____ *Relationship to Patient;* _____

*Address (Home):*_____ *City* _____ *State* _____ *Zip Code* _____ *Home phone*_____

Driver License #_____ _____ *Birthday*__/___/___ *Financial Institution* _____

*Employer*_____ *Phone, Work*_____. *Is this person currently a patient of our office? Yes No*

Insurance Information

*Name of Insured*_____ *Relationship to Patient;* _____*Birthday*__/___/___ *Social .Security #*___-___-____

Date Employed ___/___/___ *Phone, Work ;(_ _ _) _ _ _ _ Employer*_____ *Address*____ _____ *City*____ *State* _ *Zip*

Insurance Company _____*Group #* _____ *Union or Local #*_____

*Max Annual Benefit*_____ How much has been used? _____ How much is your deductible? ____is it paid this year?....

Insurance Company Address: _____ _*City* _____ *State*___ *Zip Code*_____

Do you have any additional Insurance? Yes No .If yes, please complete the following.

*ame of Insured*_____ *Relationship to Patient;* _____*Birthday*__/___/___ *Social .Security #*___-___-____

Date Employed ___/___/___ *Phone, Work ;(_ _ _) _ _ _ _ Employer*_____ *Address*____ _____ *City*____ *State* _ *Zip*

Insurance Company _____*Group #* _____ *Union or Local #*_____

*Max Annual Benefit*_____ How much has been used? _____ How much is your deductible? ____is it paid this year?....

Insurance Company Address: _____ _*City* _____ *State*___ *Zip Code*_____

Patient Acknowledgment of receipt of dental material Fact Sheet

I _____, *acknowledge I have received from Safe Dental Care Inc. / Safe Dental Care, a copy of Dental Material fact Sheet dated October 2001 and provided by Dental board of CA.*

Patients/ Guardian signature _____ *Date* _____

Welcome to Safe Dental Care

To Our Patients

We would like to welcome you to our practice and looking forward to providing you with the finest dental care.

It has been come to our attention in the servicing of members from several dental plans that they are unaware that many dental services which are available under their plans require co-payments.

We wish to provide you fine quality of care and we will be able to better service you if you will familiarize yourself with your benefits. If you have questions regarding the limitations of your plan, Please contact your insurance company for an explanation.

I understand that any co-payments due under my plan would be paid in full at the time of service.

I also understand that there will be a charge for any appointment not cancelled 24 hours in advance.

Patients/ Guardian signature _____ *Date* _____

Photograph Authorization

I hereby give my consent for Dr. Farhad Seif to take photographs, slides and/or videotape of._____ (Patient's name) face, jaw and teeth. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote cosmetic dentistry.

I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, Bridges, or dentures and these images will become part of my dental record.

I do not expect compensation, financial or otherwise, for the use of these images.

Please initial:

_____ I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing, advertising, and laboratory use.
_____ I consent to the use of my photographs, slides, and/or videotape **ONLY** for laboratory use.
_____ I **DO NOT** consent to the use of my photographs, slides, and/or videotape.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization. Unless revoked by me, this authorization expires 10 years from the date I sign below.

_____ _____
Patient's or Legal Guardian's/Representative's Signature Date

_____ _____
Dentist's Signature Date

COPY OF THIS SIGNED DOCUMENT TO BE PLACED IN PATIENT'S CHART

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I.CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain_____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain_____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain_____
4. Yes No Are you being treated by a physician now? If YES, explain
   Date of last medical exam? _____Reason for exam_____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain_____
   Date of last dental exam _____Name of last treating dentist_____
6. Yes No Are you in pain now?
   If YES, explain_____

II.HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal

Others:_____

V. WOMEN ONLY

Yes	No	Are you or could you be pregnant?	If YES, what month? _____
Yes	No	Are you nursing?	
Yes	No	Are you taking birth control pills?	

VI.ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	*Bisphosphonate (Fosamax)*	Aspirin

Please list: _____

VII. DENTAL HISTORY

Your Chief Complaint_____ Last Dental Visit,_____Last X- Rays_____

Yes	No	Do your gums bleed while brushing and/or flossing?
Yes	No	Are your teeth sensitive to hot and/or cold liquids/food?
Yes	No	Are your teeth sensitive to sweet or sour liquids/food?
Yes	No	Do you feel to any pain of your teeth?
Yes	No	Do you have any sores or lumps in or near your mouth?
Yes	No	Have you had any head, neck, or jaw injuries?
Yes	No	Do you have frequent headaches?
Yes	No	Do you clench or grind your teeth?
Yes	No	Do you bite you lips or cheeks frequently?
Yes	No	Have you ever had any difficult extraction in the past?
Yes	No	Have you ever had any prolonged bleeding following extractions in the past?
Yes	No	Have you had any orthodontic work?
Yes	No	Have you ever had instruction on the correct method of brushing your teeth?
Yes	No	Have you ever had instruction on the take care of your gums?

Have you ever experienced any of the following problems in your jaw? **(Please Circle)**

clicking pain(joint ,ear ,side of face) difficulty in opening or closing difficulty in chewing

VIII. ALL PATIENTS

Yes	No	Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, please explain: _____ _____
Yes	No	Have you ever been pre-medicated for dental treatment? If YES, why_____
Yes	No	Have you ever taken Fen-phen? If YES, when_____
Yes	**No**	**Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Patient's Signature:_____ **Date:** _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date