Tali Tehrani, DDS & Mae Aghili, DDS

Confidential Questionnaire

Welcome to our office. The first step towards providing you with the best dental care is to complete the following forms as accurately as possible. Please print your responses legibly.

Patient's First Name:_____ Patient's Last Name:_____ M.I.___

Patient's Date of Birth:____/____/____ Age:_____ Male/Female

Home Address:

Street:_____

City, State, Zip:_____

Mother's: First Name:_____ Last Name:_____ Cell Phone:_____

Father's: First Name:_____ Last Name:_____ Cell Phone:_____

Home Phone:_____ E-Mail Address:_____

Primary Insurance Information

Insured's Name:_____ Relationship to Patient:_____

Insured's Social Security Number:_____ Insured's Date of Birth:____/____/____

Insurance Name:_____ Group Number:_____

Secondary Insurance Information

Insured's Name:_____ Relationship to Patient:_____

Insured's Social Security Number:_____ Insured's Date of Birth:____/____/____

Insurance Name:_____ Group Number:_____

How did you hear about our office? _____

What is the reason for your visit today? _____

When was the patient's last dental visit? _____

Patient Name: _____

Please circle Yes or No when answering the following questions:

Are you in good health?	Yes	No
Are you taking any medications presently?	Yes	No
If yes, please indicate which medications _____		
Do you have any allergies to any medications or foods?	Yes	No
If yes, please indicate_____		
Have you been a patient at a hospital in the past five years?	Yes	No
If yes, please indicate the reason_____		

Pediatrician Name: _____ Pediatrician Phone Number: _____

Please indicate which of the following you have had or presently have:

Latex Sensitivity	Yes	No	Bruising/Excessive Bleeding	Yes	No
Asthma	Yes	No	Tumors	Yes	No
Breathing Problems	Yes	No	Chemotherapy	Yes	No
Bronchitis	Yes	No	Radiation Therapy	Yes	No
Sinus Trouble	Yes	No	Hepatitis	Yes	No
Diabetes	Yes	No	Herpes	Yes	No
Heart Murmur	Yes	No	Cold Sores/Fever Blisters	Yes	No
Aortic Stenosis	Yes	No	Arthritis	Yes	No
Congenital Heart Condition	Yes	No	Thyroid Disease	Yes	No
Heart Surgery	Yes	No	Liver Disease	Yes	No
Kidney Problems	Yes	No	Tuberculosis	Yes	No
Kidney Transplant	Yes	No	Epilepsy/Seizures	Yes	No
Ulcers	Yes	No	ADD	Yes	No
Blood Diseases	Yes	No	ADHD	Yes	No
Hemophilia	Yes	No	Autism	Yes	No
Blood Transfusions	Yes	No	Asperger's Syndrome	Yes	No
HIV Positive	Yes	No	Other _____		

Dental History

Has your child ever had an unfavorable reaction to a local anesthetic?	Yes	No
Has your child had any serious trouble associated with previous dental treatment?	Yes	No
Has your child had any form of sedation for dental treatment?	Yes	No
If yes, which kind of sedation?_____		
Does your child grind his/her teeth?	Yes	No
Does your child suck his/her thumb?	Yes	No

Please read thoroughly before signing

I have filled out this questionnaire accurately. It is my responsibility to inform your office of any changes. I realize that the financial agreements in regard to dental insurance are estimates based on available information at the time of eligibility verification and that I am ultimately responsible for all the changes incurred as a result of my child's dental treatment. Also, all emergency dental services, or any dental service performed without prior financial agreement, or insurance verification, is due at the time of service. I also understand that there may be a charge for failure to cancel an appointment without 24 hour notice.

Signature _____ **Date** _____

Doctor's Signature _____ **Date**_____

GENERAL CONSENT AND INFORMATION FORM

It is the belief of this office that you should be informed about the treatment (therapy) we may recommend, and that you should give your consent before starting treatment. The purpose of this form is to inform you of the risks that may occur in dental treatment, and other treatment choices.

RISK OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments. Drugs, medicines, analgesics, (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to ear and neck and head, nausea, vomiting, allergic reactions, itching, bruises delaying healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make any/all changes, additions and/or deletions as the Dentist deems necessary.

I hereby request and authorize the Dentist, and their Staff, to perform dental work upon me for the purpose of attempting to improve me appearance, function and the heath of my mouth, teeth bone and tissues, and understand the risks involved, as well as the possible alternative methods of treatment that have been fully explained to me. I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve my condition, or treat unhealthy or unforeseen conditions that may be encountered during treatment.

I understand that dentistry is not an exact science and that therefore reputable practitioner cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment in which I am requesting and authorizing. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist, individual or corporation, other than the treating Dentist, is responsible for my dental treatment. In order to receive treatment I contract that if there is any difference or disagreement between my attending Dentist and myself I will first present such difference or disagreement to my attending Dentist to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the grievance committee of my dental health plan, the Dental Society, or California State of Consumer Affairs Board of Dental Examiners, and agree to accept their solution in lieu of pursuing remedies by way of litigation, in consideration of helping to keep costs of treatment and services as low as possible, I also understand that this agreement is binding on my heirs and all other family members.

Alternatives and possible untoward reactions have been explained to me in detail and clearly, including (but not limited to) bleeding, scarring numbness, fractured jaw, and allergic reaction which on occasion can be life threatening. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAD BEEN EXPLAINED TO ME.

SIGNATURE:_____ **DATE:**_____
PATIENT OR LEGAL REPRESENTATIVE

SIGNATURE:_____ **DATE:**_____
DOCTOR