Brentwood Dental Group

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Welcome to our Practice

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________* ____________* ____ ____________
Last First MI Preferred Name

Title: ________ Mr/Ms/Mrs/etc

Gender:* ◯ Male ◯ Female

Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* ____________ **Prev. Visit:** ____________ **Email Address:** ____________

Phone: ____________* ____________ ____________ ______
Home Mobile Work Ext

Best time to call: ____________

Address: ____________* ____________
Address 1 Address 2

____________* ______* _____-____*
City State Zip Code

Whom may we thank for referring you to our practice?

☐ Facebook ☐ Google ☐ Instagram ☐ Radio ☐ Tiktok ☐ TV ☐ Twitter ☐ Website

Name of person, office or other source referring you to our practice:

____

____

Emergency Contact: *

____

____

Dental Information

What is your immediate concern?

____

____

Previous Dentist Name and Phone Number:

____

____

Date of most recent dental exam and dental x-rays: * ____________

Is there anything about the appearance of your smile that you would like to change?

____

____

Check all that apply: *

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

____

____

____

____

Medical Health History

Please explain/clarify any conditions or alerts selected above:

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Allergies
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Dizziness/Fainting
☐ Drug Abuse/Use	☐ Epilepsy	☐ Excessive Bleeding	☐ Glaucoma
☐ HIV/AIDS	☐ Head Injuries	☐ Headaches	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure	☐ HighBlood Pressure
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Nervous Disorders	☐ Osteoporosis	☐ Pacemaker	☐ Pregnancy
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Stomach Problems	☐ Stroke	☐ Tobacco Use
☐ Tuberculosis	☐ Tumors	☐ Tylenol	☐ Ulcers
☐ Venereal Disease	☐ x - OTHER		

Conditions/Alerts:

____

____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

____

____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med: *

____

____

Name of your Physician and Phone Number:

____

____

Preferred Pharmacy and Phone Number:

____

____

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

____

____

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or your are the parent/guardian of the patient.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ____________ Last ____________ First ____ MI ____________ Preferred Name

Title: ____________ Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **SS#:** ___-__-____ **DL#:** ____________

Email Address: ____________ **Best time to call:** ____________

Phone: ________ Home ________ Mobile ________ Work ________ Ext ________ Fax ________ Other

Address: ____________ Address 1 ____________ Address 2

____________ City ________ State _____-____ Zip Code

Primary Dental Insurance

Name of Insured: ____________ Last ____________ First ____ MI

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

Insured's Address: ____________ Address 1 ____________ Address 2

____________ City ____ State _____-____ Zip Code

Insured's Employer Name: ____________

Employer Address: ____________ Address 1 ____________ Address 2

____________ City ____ State _____-____ Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____________

Insurance Address: ____________ Address 1 ____________ Address 2

____________ City ____ State _____-____ Zip Code

Insurance Company Phone Number: ____________

Secondary Dental Insurance

Name of Insured: ____________* Last ____________* First ____ MI

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

Insurance Plan Name:* ____________

Medical Insurance

Name of Insured: ____________* Last ____________* First ____ MI

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

Insurance Plan Name:* ____________

Insurance Authorization:

☐ ***By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. 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 unless other arrangements are made.

Patients with dental insurance understand that all dental services 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 patient's insurance forms or assist in making collections from insurance companies and will credit any 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 1.5% 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 any fee estimate 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 by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 to discuss this statement or my treatment.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

Consent for Internet Communication

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Agreement to Receive Electronic Communication, Text Message and Email

SMS/Text Message By selecting this option, I agree that Dr Haroun Rostami/ Brentwood Dental Group team may communicate with me electronically using my provided SMS number above. I am aware that there is some level of risk that third parties might be able to read SMS. I am responsible for providing Dr Haroun Rostami/ Brentwood Dental Group team any updates to my SMS number and can withdraw my consent to this electronic communication by contacting the office.

SMS/Text Message By selecting this option, I agree that Brentwood Dental Group/ Dr Rostami's dental office may communicate with me electronically at the SMS number above. The communication must be very brief and must not include protected health information. Information I may receive should be limited to my appointments schedule ONLY. *

◯ Yes ◯ No

Email By selecting this option, I agree that Dr Haroun Rostami/ Brentwood Dental Group team may communicate with me electronically using my provided email address above. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing Brentwood Dental Group any updates to my email address and can withdraw my consent to this electronic communication by contacting the office.

Email By selecting this option, I agree that Dr Haroun Rostami/ Brentwood Dental Group team may communicate with me electronically at the email provided above. The communication must be very brief and must not include protected health information. Information I may receive should be limited to my appointments schedule ONLY. *

◯ Yes ◯ No

Consent for X-rays and Intraoral Photos

The standard of care in our office includes the use of dental radiographs (x-rays) and Intraoral photos. The most common type of x-rays we will take are Full mouth X-ray and Bitewings, those x-rays are helpful in screening both upper and lower jaws and help diagnose the following: ?? missing teeth ?? Orthodontic considerations ?? Periodontal conditions (gum and bone disease) ?? Defects and malignancies of the bones and jaw ?? Evaluation of wisdom teeth ?? Evaluation of health of tooth, roots, crowns, bridges and implants. ?? Abscesses (infections) within the bone associated with teeth or otherwise.

These x-rays and photos are usually part of your normal dental hygiene/examination appointments and are necessary to provide the level of diagnosis and care we strive for. At the time of your appointment our staff will notify you if you are due to have x-rays taken. If you have questions or concerns, please feel free to ask any of our staff members. Our protocol for comprehensive exam includes Intraoral Diagnostic photos. This may not be covered by some insurances. In that case, this will be patient responsibility and our office charges $200.00 for it. We value you as a patient and take pride in providing you with optimum dental care.

Additional Disclosure Authority

Patients Name : * ________________________

Signature: * ________________________

Date: * ________________________

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY ________________________

◯ Yes ◯ No

OTHER (Please specify) ________________________

◯ Yes ◯ No

Dentist-Patient Arbitration Agreement

Article 1: Agreement to arbitrate: It is understood that any dispute as to dental malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement binds all parties whose claims may arise out of or relate to treatment or services provided by the dentist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of occurrence giving rise to any claim. In case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims of monetary damages exceeding the jurisdictional limit of the small claims court against the dentist and the dentist's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the dentist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the dentist, any fee dispute whether or not subject of any existing court action shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share or the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity, which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that the provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Patients Initial * ________________________

Article 4: General Provisions: All claims based upon the same, transaction or related Circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred If (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statuette if limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration's.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the dentist within 30 days of signature and if not revoked will govern all dental services received by the patient.

Article 6: Retroactive Effect: if patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below: Effective as of the date of first dental services.

Patients Initial * ________________________

If any provisions of this arbitration agreement are held invalid or unenforceable, the remaining provisions shall remain in force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

Patients Initial * ________________________

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Patients Name * ________________________

Signature : * ________________________

Date: * ________________________

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient: *

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☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: ___________