Smile Make Over Center
Financial Agreement

Financial Considerations

It is to your advantage, to understand every aspect of your dental care, before beginning treatment that you consider your level of financial commitment so that we can assist you in prioritizing your dental treatment if necessary. Please be aware that during the course of the treatment, additional clinical findings may necessitate a change in any treatment recommendation with the possible changes in cost. It is our policy to make definite financial arrangements before any treatment is started, that all treatment rendered be paid in full by completion.

Insurance policy

We are happy to assist you with your dental insurance. As a courtesy to you, we will complete all forms pertaining to your treatment and send them promptly to your insurance company. We will estimate out of pocket expenses and accept your carrier's assignment of benefits if the carrier offers an assignment and if signed below. Payment of deductibles, copayments and procedures not covered by your plan are due at the time services are rendered. If you would pay for your treatment and collect the insurance benefits yourself, please let us know so that we can file your claims accordingly. We ask that you read your dental policy to be sure you are fully aware of your dental plan, waiting periods, plan maximums and treatment exclusions. It is our goal to ensure that you receive the maximum benefit from your dental insurance plan, while providing you with different treatment options. We do require payment in full of any outstanding account balance within 45 days from the date treatment is completed. This is required even if there are insurance benefits pending after 45 days and if received they will be reimbursed to you.

Payment Options

Please select the option you wish to utilize for payment of your dental treatment. For those with dental insurance, your selection will be utilized to pay your deductibles, co-payments, and for procedures which are not a benefit of your dental plan. The option you choose will be kept as part of your permanent record. However, you may change your payment selection at any time.

Payment Options

1. Cash
2. Check
3. Major Credit Cards
4. Care Credit

If you think you might want to utilize our financing option, please request an application at the front desk.

I have read and understand this agreement

Signature _____ **Date** _____

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to your information.

Our legal duty

Federal and state law requires us to maintain the privacy of your health information. The law also requires us to give this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practice we describe in this notice while it is in effect. This notice takes effect April 14, 2003 and will in effect until we replace it.

Uses and disclosures of health information

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may disclose your treatment information with a dentist, physician, or other health care provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or payment with your health care. Before doing so, we will provide you with an opportunity to object to our use of disclosure. If you are not present or in the event you are incapacitated or an emergency we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable interferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or similar forms of health information. We may use or disclose information about to notify or assist in notifying a person involved in your care of your location and general condition.

Appointment Reminders: disclosure of your health information to provide you with appointment reminders such as voicemail messages, postcard, letters and emails.

If this practice is sold, your information will become the property of the new owner. You may request, in writing that we not use or disclose your information as described above, We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal used, As we will need to contact you or your family members from time to time, we will use whatever address and telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have a right to see and receive a copy of your information, with a few exceptions. Give us a written request regarding the information you want to see, If you also want a copy of your records, we may charge you a reasonable fee for the copies. You have the right to amendment or change your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make changes you request, but we will be happy to include the statement in your file, If we agree to an amendment of change, we will not remove nor alter any earlier documents, but will add new information. You have a right to receive a copy of this notice. If we change any of the details of this notice, we will notify of the changes in writing. You may file a complaint with the department of health and human services, 200 Independence Ave. S.E. Room 509F, Washington dc 2O2O1. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office at 619-574-6678.

Date: _____

Print Name: _____

Signature: _____

Dental Information and Acceptance Form

Patient Name: _____

1. **Health Information**
   I agree to disclose all previous illnesses, medical and dental history, (e.g. gum disease) including all medications. Undisclosed medical information and current medication, allergies or illness are risk factors. I agree to allow the use of my information only where it is necessary, for treatment or to process insurance claims.

2. **Fee for additional care specialty care**
   I understand I may need treatment beyond what is originally planned (e.g a crowned tooth may still need a root canal and may be referred to a specialist for care.)

3. **Limitations of insurance coverage**
   Often there are charges beyond what insurance will pay (e.g sterilization fee, nitrous oxide, temporary dentures, bleaching, or cosmetic work.) Also, as a service to our patients, this office will file insurance claims on their behalf. However, I understand that what I may be quoted on my portion (co-payment) is only an estimation if we do not have a pre- authorization (per patient request). I agree to be financially responsible for what my insurance does not cover.

4. **Missed appointments & 2 Business day notice**
   I agree to give a 2 business day notice of cancellation or I will pay the **broken appointment fee of $50** per hour scheduled. There are certain situations where there are emergencies, and those will be handled individually. I understand that any failure to show up to appointment will be charged the missed appointment fee.

5. **Requesting Transfer**
   Professional courtesies occur between dental offices. I understand that any previous records will be sent directly to this dental office only. I also understand the there is a **$25 fee for duplicating or releasing x-rays, intra oral pictures, etc.**

6. Hygiene appointments

If I am more than 15 minutes late for my cleaning appointment, I will either accept what appointment time is left, or I will reschedule and pay the broken appointment fee.

7. <u>Appointment times and emergency care</u>

It is our office philosophy to be available for any guest in pain and discomfort, especially in an emergency situation. This courtesy is extended to all patients and we ask for your understanding when these unexpected situations arise. Out of respect for your time we will keep you informed of this and if there will be a longer than expected wait time. We thank you in advance for your patience.

8. <u>Crowns, porcelain restorations and fillings warranties</u>

Patients often ask about the limitations of these restorations. These restorations respond much like natural teeth and can chip if used to bite hard objects. Home care is very important part of maintaining your restoration. This means brushing and flossing daily. If home care is neglected this may result in loss of the restoration from decay or gum disease. Dr. Rastegar will replace your restoration if these conditions are met, these conditions include, always staying on time with your cleaning appointments whether you are 3, 4 or 6 month regiment. As well as obtaining and consistently wearing a Night guard if Dr. Rastegar has recommended one for you. Maintaining these conditions will allow us to fulfill this warranty.

Your Warranty is covered as follows:

1st YEAR -100%COVERAGE
2nd YEAR -80% COVERAGE
3rd YEAR -60% COVERAGE
4th YEAR -40% COVERAGE
5th YEAR -20% COVERAGE
6th YEAR - COVERAGE ENDS.

9. **<u>Deposit For Appointment</u>**

I understand there is a **<u>$50 deposit</u>** required for any appointment 1hour or longer and the deposit will be applied towards the scheduled treatment. I also understand that the deposit is non refundable if the appointment is a no show or cancelled less than **<u>48</u>** **<u>hours in advance</u>**.

If you have any questions, please feel free to ask any of our staff members or Dr. Rastegar. We will be happy to answer any questions you may have.

Patient Signature **Date**

_____ _____

<u>Medical Information Release Form</u>
<u>(HIPAA Release Form)</u>

Name:_____ Date of Birth:_____

<u>Release Information</u>

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] spouse _____
[ ] child (ren) _____
[ ] other _____

[ ] information release to anyone.

This release of information will remain in effect until terminated in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave message asking to return your call
[ ] _____

The best time to reach me is (day)_____ between (time)_____

Text and Email :

( ) Please check the Box if we are able to send Text and Email Review or Survey messages.

Signed: _____ Date:_____

Smile Makeover Center

The office of Dr. Farhoud Rastegar, and Associates
1450 Frazee Rd. Ste. #209
San Diego CA, 92108

PATIENT CONSENT TO TREATMENT

Patient Name:_____

In reading and signing this form it is understood that ENGLISH is the language that understand and use to communicate. I give my consent for the Doctor(s) to perform any of the following procedures. If any unforeseen condition should arise calling for the Doctor(s) judgment, I request and authorize the doctor to do whatever may deem advisable, including referral to another dentist for specialist. I understand the cost of this referral would be by responsibility.
Initials:_____

DRUGS, MEDICATIONS, and ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, 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, nor operate any vehicle or hazardous device while taking medications and/ or drugs, or until fully recovered from their effects. (This includes a period of at least 24 to 48 hours after my release from surgery.)

I understand that occasionally, upon reject of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide (N20) or Valium or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side effects, such as obstructions of airway.

Initial_____

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 efforts at proper oral hygiene (i.e, brushing and flossing) and maintaining regular check- ups. PERIODONTICS- I understand that I have a serious condition, causing gum and bone inflammation and/ or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacement and/ or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated may require extraction.

Initials_____

Removal of Teeth

I understand that the purpose of this procedure / surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists w/out treatment or surgery, my present oral condition will probably worsen in time.

POTENTIAL RISKS INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:

- Post-op discomfort, swelling, bleeding, sensitivity to hot and cold, gum shrinkage, looseness in teeth, delayed healing (dry-Socket), and or infection (may cause more treatment).
- Limitation of opening, stiffness of facial and/ or neck muscles, change in bite, or TMJ (jaw joint) difficulty, possibly causing physical therapy or surgery.
- Residual root fragments left when complete removal would require extensive surgery or needless surgical complications.
- Possible bone fracture-may require wiring or surgical treatment.
- Opening of sinus-requiring additional surgery.
- Injury to the nerve Initial_____

FILLINGS

I have been informed of the reason for a composite filling restoration is to replace the tooth structure lost due to decay. In cases where very little toothy structure remains, I will need to receive more extensive treatment (such as Pulp-cap, RCT, Post Build Up and Crown.) This would necessitate separate charge. Initial_____

ENDODONTIC TREATMNET (ROOT CANAL THERAPY)

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments and the consequences of non – treatment. I understand that the root canal treated tooth will be brittle and must be anchored with a post and protected with a crown. I understand the risks can include the following;

- Post-op discomfort – may last for a couple days and prescription may be needed. Swelling and infection may last for several days after treatment with restricted jaw opening.
- Breakage of instruments and perforation-may break inside and may need surgical removal. Risk or temporary or permanent numbness in treated area.

OPEN AND MEDICATION OR PULPOTOMY

I understand that this is not permanent treatment and is to take me out of pain and medicate. I also understand I need to pay and finish root canal. If failure of Root Canal occurs, the treatment may have to be redone and/ or may need extraction.

Initial_____

Crown and Bridge (Caps)

I understand that it may not be possible to match exactly the natural teeth with the artificial teeth. I understand that during the prep of a crown pulp exposure may occur needing possible root canal therapy. I also understand that crowns and bridges need to be keep clean with proper oral hygiene and recall cleanings otherwise there may be recurrent decay leading to further treatment.

Initial_____

Dentures Complete or Partial

The problem of wearing dentures has been explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone movement. I also understand that I may never fully be able to wear my dentures to my satisfaction.

Pedodontics (Children Dentistry)

I understand that the following procedures are used in Smile Makeover Center, as well as being accepted in the dental professions.

- Positive Reinforcement: Rewarding the child who portrays desirable behavior, by use of toys, balloons, and stickers.
- Voice Control; changing the tone or increasing the volume in the doctor's voice gains Attention of a disruptive child.
- Nitrous Oxide: (N2O) & Oral sedation: is a mild gas that is mixed with oxygen and nitrous used to sedate a person. It is administered through a mask and placed over the Childs nose. Oral sedation is medications administered to the child to help them relax.

I understand that with the use of injection, used to numb the tooth, there may be a possibility that the child may inadvertently bite their lip causing injury.

Initials _____

I UNDERSTAND THAT NO GUARANTEE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/ OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECCOMENDATION OF THE DOCTOR WHILE I AM UNDER HIS CARE.

I CERTIFY THAT I HAVE HAD AN OPPORTUITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE AND CONSENT TO THE TREATMENT BEING DONE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT SMILE MAKE OVER CENTER PROVIDES DENTAL CARE AND SERVICES WITHOUT DISCRIMINATION BASED ON RACE OR MARITAL STATUS AND PROTECTS PRIVACY OF EACH OF THEIR PATIENTS.

SIGNATURE _____

RELATIONSHIP_____ DATE_____

DOCTOR_____ DATE_____

Health History

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
Do you wear contact lenses?	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

WELCOME

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Birthdate _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Phone (____) _____ Work (____) _____ Ext _____ Alt.Phone (____) _____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (____) _____ Work Phone (____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____