Name _____

Address _____

City _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Email _____

Employer _____ Occupation _____

Date of Birth _____ Name of Spouse or Parent _____

Dentist / Referring Doctor's Name _____

Have You Been a Patient Here Before? _____

Pharmacy Information:

Pharmacy Name _____

Address _____

Phone _____

Have You Had Any of the Following? (Yes or No)

Rheumatic Fever _____ Hepatitis _____

Diabetes _____ HIV/AIDS _____

High Blood Pressure _____ Anemia _____

Low Blood Pressure _____ Leukemia _____

Heart Trouble _____ Stroke _____

Tuberculosis _____ Asthma _____

Joint Replacements _____ Prosthetic Heart Valve _____

Any Other Medical Condition or Surgery? _____

Has a Doctor Ordered You To Pre-medicate Prior to Dental Treatment? _____

Why? _____

Have You Had an Allergic Reaction to Any Medication? (Yes or No)

PENICILLIN _____ ASPIRIN _____ LATEX _____ OTHER _____

Have You Experienced an Unusual Reaction to Dental Injections? _____

Have You Ever Experienced Prolonged Bleeding? _____

List **ALL** the Medications You are Taking: _____

Are You Pregnant or Nursing? _____

_____

Signature _____ Date _____

Michael Baharestani D.D.S. PC

FINANCIAL POLICY - PLEASE READ THOROUGHLY AND INITIAL THE HIGHLIGHTED AREAS! We realize that every persons financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. However, **WE CANNOT GUARANTEE ANY ESTIMATED COVERAGE.** Because the insurance policy is an agreement between you and the insurance company, **YOU** are directly responsible for all charges. Please know that we will do everything possible to see that you receive the maximum benefits from your policy.

If, for some reason, your insurance company has not paid their portion within 30 days from the filing of the claim, you are responsible for payment at that time. **IT IS YOUR RESPONSIBILITY TO FOLLOW-UP WITH THE INSURANCE COMPANY REGARDING NONPAYMENT OF YOUR CLAIM**

_____ All office visits or diagnostic fees are to be paid **in full** at this office If you do not have dental insurance, payment is expected **in full** at time of treatment. We can make financing arrangements with you ahead of time.

_____ For participating insurances (those insurances in which this office has agreed to accept that company's payment rates), the **applicable co-payment is to be paid at the of treatment. This co-payment is only an estimate; your actual share may vary.**

OTHER FEES

_____**NO SHOWS** -Our office confirms all treatment appointments in advance. If you confirm an appointment, and then do not come at your scheduled time, or cancel without giving 24 hour notification, you will be assessed an $85 charge. Your insurance will not cover this fee.

PARTIAL TREATMENT - If you begin endodontic therapy and then decide on your own not to complete treatment, you are responsible for the appropriate half-treatment fee, and all subsequent possible oral health complications.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE. I HEREBY AUTHORIZE THE ABOVE NAMED ENDODONTIST TO FILE INSURANCE ON MY BEHALF AND AUTHORIZE PAYMENT DIRECTLY TO HIM FOR THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I AM AWARE THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY.

_____

PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**

Consent for Endodontic Treatment

The doctor has explained to me that there are certain **inherent and potential** risks in any treatment plan or procedure. Many factors contribute to the success of root canal treatment and cannot be determined in advance. Therefore, in some cases treatment may have to be discontinued before it is completed, or may fail following treatment. Some of these factors are: my resistance to infection, calcifications, location and shape of the canals. Sometimes other procedures may be needed to save the tooth such as: **apical surgery**, crown lengthening surgery or it may need to be extracted.

I understand that the following may be inherent or potential risks for the treatment I will receive: swelling, sensitivity, bleeding, pain, **persistent or recurrent infection, numbness (paresthesia) and/or tingling sensation** in the lip, tongue, chin, gums, cheeks and teeth, which is usually transient but on the infrequent occasions may be permanent; reactions to injections; changes in occlusion (biting); jaw muscle cramps and spasm, temporomandibular joint difficulty (such as trismus); loosening of teeth, existing crowns or bridges; **damage of existing restorations**; referred pain to ear, neck and head; **delayed healing**; sinus perforations and sinus infection; treatment failure; complications resulting from the use of dental instruments (broken instruments), perforations of the root canal due to curved roots or existing conditions (such as **calcification**), medications, anesthetics and injections; discoloration of the face; **adverse reactions** to medications, anesthetics and injections causing drowsiness and lack of coordination. **Antibiotics may inhibit the effectiveness of birth control pills.** Premature tooth loss which may result from existing cracks or fractures and ones that may occur during or after the toot canal treatment or from progressive periodontal disease. **Allergic reactions** to antibiotics or anesthesia or other medications/materials used in the office may take place. I also understand that, with respect to a root canal, the tooth is in a weakened state compared to a natural tooth. That makes the tooth subject to fracturing, or breaking. I also understand that a tooth, which has had a root canal, is still at risk for further decay and even infection,

I acknowledge that **no guarantees or assurances have been given** by anyone as to the results that may be obtained. I have been given the **opportunity to question the doctor** concerning the nature of treatment, the risks of the treatment and the alternatives to this treatment. **I understand that by doing nothing I run the risk of developing a severe infection, and losing a tooth.**

I have been told that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication, reporting to the office any change in my health status, and returning to my general dentist for permanent restoration.

**ONLY ROOT CANAL THERAPY WILL BE PERFORMED AT THIS OFFICE. THE PERMANENT RESTORATION (FILLING, CROWNING, ETC.) WILL BE DONE BY YOUR REGULAR DENTIST WHO YOU SHOULD FOLLOW-UP WITH WITHIN 30 DAYS.*

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name:_____ **Date of Birth:**_____

I have received this practice's Notice of Privacy Practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

· A statement that this practice is required by law to maintain the privacy of protected health information.

· A statement that this practice is required to abide by the terms of the notice currently in effect.

· Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.

· A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.

· A description of uses and disclosures that are prohibited or materially limited by law.

· A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

· My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

o The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliotory actions will be used againts me in the event of such a complaint.

o The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.

o The right to receive confidential communications of protected health information.

o The right to inspect and copy protected health information.

o The right to amend protected health information.

o The right to receive an accounting of disclosures of protected health information.

o The right to obtain a paper copy of the Notice of Privacy Practice from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practice and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's currect Notice of Privacy on request.

_____

_____

Signature Date

Please check all that apply:

YES	NO	
		You, a member of your household, or a close contact of yours, have a fever, cough, shortness of breath, or a sore throat.
		In the past 14 days, you, a member of your household, or a close contact of yours have travelled to a country or area with ongoing COVID-19 outbreak. (e.g. China, Europe, Iran, South Korea)
		You have been exposed to someone who has tested positive for COVID-19 or has been exposed to COVID-19.
		None of the above.

I, _____, knowingly and willingly consent to have emergency dental treatment during the COVID-19 pandemic at **Dr. Michael Baharestani DDS PC.**

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show the symptoms and still be highly contagious. It is impossible to determine who has it and who does not have it given the current limits in COVID-19 testing.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visit of other dental patients, the characteristics of the virus, and the characteristics dental procedures, that I have an elevated risk of contracting the virus simply by being in the office. _____ **(Initial)**
- I have been made aware of the CDC, CDA, and ADA guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. _____ **(Initial)**
- I confirm I am seeking treatment for a condition that meets these criteria. _____ **(Initial)**

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever _____ **(Initial)**
- Shortness of Breath _____ **(Initial)**
- Dry Cough _____ **(Initial)**
- Sore Throat _____ **(Initial)**

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. _____ **(Initial)**

- I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by COVID-19. _____ **(Initial)**
- I verify that I have not traveled domestically within the United States by the commercial airlines, bus, or train within the past 14 days. _____ **(Initial)**

_____ _____ ____/____/_____

Print Name (If child/Guardian Name) **Signature (If child/Guardian Signature)** **Date Signed**