



Mohammad Khalifeh, DDS, MS 5757 Wilshire Blvd., # 5, Los Angeles, CA 90036, Tel: (323) 933-3855

PATIENT INFORMATION

PATIENT NAME

FIRST: _____ MI: _____ LAST: _____ NICK NAME: _____

DOB: _____ AGE: _____ SSN: _____ MALE FEMALE

SINGLE MARRIED DIVORCED WIDOWED EMAIL: _____

ADDRESS: _____ APT: _____ CITY: _____ ST: _____ ZIP: _____

HOME #: _____ CELL#: _____ WORK#: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? : _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____ PH#: _____

RESPONSIBLE PARTY (IF SAME AS ABOVE, PLEASE SKIP)

FIRST: _____ LAST: _____ RELATIONSHIP TO PATIENT: _____

DOB: _____ SSN: _____ RELATIONSHIP TO PATIENT: _____

HOME #: _____ CELL#: _____ WORK#: _____

ADDRESS: _____ APT: _____ CITY: _____ ST: _____ ZIP: _____

EMPLOYMENT

EMPLOYER NAME: _____ ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PPO HMO PH#: _____

MEMBER ID: _____ GROUP # _____ INSURED NAME: SELF OTHER

IF OTHER, NAME: _____ DOB: _____ SSN# _____ RELATIONSHIP: _____

SECONDARY INSURANCE: _____ PPO HMO PH#: _____

MEMBER ID: _____ GROUP # _____ INSURED NAME: SELF OTHER

IF OTHER, NAME: _____ DOB: _____ SSN# _____ RELATIONSHIP: _____

MEDICAL INSURANCE: _____ PPO HMO PH#: _____

MEMBER ID: _____ GROUP # _____ INSURED NAME: SELF OTHER

IF OTHER, NAME: _____ DOB: _____ SSN# _____ RELATIONSHIP: _____

WILSHIRE SMILE STUDIO

the multi-specialty dental group

HEALTH QUESTIONNAIRE

PLEASE ANSWER ALL QUESTION, CHECK YES OR NO AND FILL IN BLANK SPACES WHERE INDICATED.
ANSWER TO THE FOLLOWING QUESTIONS, OUR RECORDS WILL BE CONSIDERED CONFIDENTIAL.

1. ARE YOU IN GOOD HEALTH? YES NO
YOUR LAST PHYSICAL WAS ON: (DATE) _____ HEIGHT: _____ WEIGHT: _____
2. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? YES NO
A. IF SO, WHAT IS THE CONDITION BEING TREATED?: _____
B. PHYSICIAN NAME: _____ PHONE #: _____
3. HAVE YOU EVER HAD A SERIOUS ILLNESS, OPERATION OR HAVE BEEN HOSPITALIZED?
A. IF YES, FOR WHAT? _____ WHEN? _____
4. DO YOU DRINK ALCOHOLIC BEVERAGES? YES NO
5. HISTORY OF ALCOHOL ABUSE? YES NO
6. RECREATIONAL DRUGS IN THE LAST 6 MONTHS? YES NO
7. HISTORY OF DRUG ABUSE? YES NO
8. DO YOU SMOKE? YES NO
9. DO YOU USE TOBACCO? YES NO

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS?

HEART CONDITIONS

- HIGH BLOOD PRESSURE YES NO
LOW BLOOD PRESSURE..... YES NO
ANGINA / CHEST PAIN..... YES NO
FAINTING OR SEIZURE..... YES NO
IRREGULAR HEARTBEAT..... YES NO
HEART ATTACK..... YES NO
HEART BYPASS..... YES NO
HEART PACEMAKER..... YES NO
STROKE..... YES NO
ANEMIA/ RHEUMATIC FEVER..... YES NO
HEART VALVE DAMAGE YES NO

LIVER DISEASE

- HEPATITIS (CIRCLE A / B / C) YES NO

BREATHING/ LUNG CONDITION

- ASTHMA YES NO
ALLERGIES/ HAY FEVER..... YES NO
BREATHING DIFFICULTIES..... YES NO
SNORING / SLEEP APNEA..... YES NO
TUBERCULOSIS..... YES NO
SINUS PROBLEMS YES NO
MENTAL HEALTH PROBLEMS..... YES NO

IMMUNOSUPPRESSED/BLOOD DISEASE

- HIV POSITIVE..... YES NO
AIDS..... YES NO
SEXUALLY TRANSMITTED DISEASE..... YES NO

DELAY IN HEALING..... YES NO



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ORGAN CONDITION/ DISEASE

PANCREAS / DIABETES..... YES NO

KIDNEY/ DIALYSIS..... YES NO

EYES/ GLAUCOMA..... YES NO

THYROID..... YES NO

NEUROLOGICAL/ EPILEPSY..... YES NO

CANCER

LOCATION: _____

SURGERY..... YES NO

JOINT CONDITION

ARTHRITIS..... YES NO

ARTIFICIAL KNEE REPLACEMENT..... YES NO

ARTIFICIAL HIP REPLACEMENT..... YES NO

SWOLLEN ANKLES..... YES NO

OTHER: _____

CHEMO THERAPY..... YES NO

RADIATION TREATMENT..... YES NO

10. HAVE YOU HAD ANY DISEASE, SERIOUS ILLNESS/ SURGERY CONDITION OR PROBLEM NOT LISTED? YES NO
IF YES, EXPLAIN: _____

11. HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS EXTRACTIONS, SURGERY OR TRAUMA? YES NO

12. DO YOU BRUISE EASILY? YES NO

13. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION? YES NO
IF YES, EXPLAIN CIRCUMSTANCES _____

14. HAVE YOU HAD SURGERY OR XRAY TREATMENT FOR A TUMOR, GROWTH OR OTHER CONDITION IN YOUR MOUTH OR LIPS?
..... YES NO
IF YES, WHEN? _____

15. HAVE YOU HAD ANY ADVERSE REACTION WITH PREVIOUS DENTAL TREATMENT? YES NO
IF YES, EXPLAIN: _____

16. HAVE YOU HAD ANY ADVERSE REACTION ASSOCIATED WITH PREVIOUS MEDICAL PROBLEM? YES NO
IF YES, EXPLAIN: _____

17. HAVE YOU BEEN ON ANY IV BISPHOPHONATES FOR CHEMOTHERAPY (I.E: ZOMETA), OR ORAL BISPHOSPHONATES IN THE
LAST 5 YEARS FOR OSTEOPOROSIS (I.E: FOSAMAX OR ACTONEL)? YES NO
IF YES, EXPLAIN: _____



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18. ARE YOU TAKING ANY DRUG OR MEDICINE? YES NO

IF YES, LIST ALL MEDICATION: _____

19. ARE YOU TAKING ANY OF THE FOLLOWING:

ASPIRIN..... YES NO

ANTIBIOTICS..... YES NO

SULFA DRUGS..... YES NO

MEDICINE FOR HIGH BLOOD PRESSURE... YES NO

TRANQUILIZERS..... YES NO

INSULIN YES NO

TOLBUTAMIDE..... YES NO

DIGITALIS OR DRUGS FOR

HEART PROBLEMS YES NO

ANTIICOAGULANTS..... YES NO
(BLOOD THINNER)

CORTISONE (STEROIDS) .. YES NO

NITROGLYCERIN..... YES NO

OTHER: _____

20. ARE YOU ALLERGIC OR HAVE REACTED
ADVERSELY TO THE FOLLOWING:

PENICILLIN YES NO

OTHER ANTIBIOTICS YES NO

ASPRIN YES NO

LATEX..... YES NO

LOCAL ANESTHETIC..... YES NO

IODINE..... YES NO

SULFA DRUGS..... YES NO

BARBITURATES, CODEINE, SEDATIVES YES NO
OR SLEEPING PILLS

OTHER: _____

WOMEN ONLY

ARE YOU TAKING BIRTH CONTROL? YES NO

ARE YOU PREGNANT? YES NO

ARE YOU NURSING/BREASFEEDING? YES NO

NOTE: ANTIIOBiotics (SUCH AS PENICILLIN)
MAY ALTER THE EFFECT OF BIRTH CONTROL PILLS. CONSULT YOUR
PHYSICIAN/GYNECOLOGIST FOR ASSITANCE REGARDING ADDITIONAL

I HAVE FILLED OUR THIS QUESTIONNAIRE COMPLETELY, I HAVE ADVISED AND WILL ADVISE IN THE FUTURE TO WILSHIRE SMILE
STUDIO ALL MEDICAL PROBLEMS OF WHICH I AM AWARE OF.

PRINT NAME: _____

DATE: _____

SIGNATURE: _____

(PARENT/GUARDIAN IF MINOR)

DOCTOR'S SIGNATURE: _____

DATE: _____

NOTES: _____



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Our Commitment

We feel it is important to share information with you on “how and why” our practice prides itself on spending quality time with each individual patient and provide quality dentistry at reasonable costs. We do this by having the office staff and patients acknowledge and abide by certain commitments.

COMMITMENT TO TREATMENT POLICY

In most cases, we believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, further disease, and additional expenses. Therefore, if a plan is agreed upon and started, it, in most cases, should be completed. Rest assured that we would never move forward with treatment without your consent. We ask that you consent to discuss finances over the phone, email and mail. We are more than happy to send you or another dental provider your dental images for a \$35 fee.

COMMITMENT TO APPOINTMENT POLICY

We reserve time for each patient in our practice and rarely keep patient waiting. An appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you promptly and that you will be present for that appointment. Our answering machine does not accept appointments cancellations or changes. We must have mutual respect for each other's time. We must charge a cancellation fee of \$50 per hour of schedule treatment if less than 72 hours' notice of cancellation is not given.

COMMITMENT TO FINANCIAL AGREEMENT POLICY

We believe we have a responsibility to you to use our best professional care, skill and judgment in planning and delivering your dental treatment. We can only fulfill this mission through a bond of trust with you to pay for services. We will not move forward with treatment unless you are fully aware of fees and expected payment and then only with your consent. There will be a \$35 fee for all returned or stopped checked after services are rendered. If you have an overdue balance and if we send your account to collections, we need to charge an interest rate of 10% from the date of delinquency (delinquency is a balance 30 days overdue from the date of billing) and if there was any courtesy adjustment, it will be reserved and full balance owed.

INSURANCE POLICY

Our office does not diagnose, render treatment or establish fees according to any insurance tables or allowances. Our fees are based on the care, skill and judgment of the professionals delivering the services, and the cost of operating a dental office dedicated to excellence. Please remember that we work 100% for you, not your insurance company. Your dental plan may only cover charges for the least expensive results. We refuse to compromise our standards by offering anything less than the complete care that you deserve. We will file insurance claims as a courtesy to you. Please understand that YOU are ultimately responsible for any amounts not covered by your insurance plan. You give us the authorization assign all medical and dental payments from your insurance to us directly. You understand that you are financially responsible for all the charges not covered or paid by your insurance for whatever reason.

I have read and thoroughly understand the above statements.

PATIENT NAME

PATIENT SIGNATURE

DATE



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RECEIPT OF DENTAL MATERIAL FACT SHEETS AND NOTICE OF PRIVACY PRACTICES

- As of January 1, 2002, the Dental board of California now requires that we provide to our patients a copy of the Dental Material Fact Sheets (DMDS).
- As of April 14, 2003, the Health Insurance Portability and Accountability Act (HIPAA), we provide to our patients a copy of our Notice of Privacy Practices.

I, _____, the undersigned, acknowledge that I have read the MSDS and HIPAA documents. Please inform the staff if you like copies for your file.

PATIENT SIGNATURE

DATE



DENTAL EVALUATION

NAME: _____

1. Reason for your visit today? _____
2. Date of last dental visit: _____
3. Name of previous dental office/dentist: _____
4. Do your gums bleed when you brush? _____
5. How often do you floss? _____
6. Have you or a family member ever been treated for periodontal disease? YES NO
7. Have you ever had an oral cancer screening? NO YES

8. Have you ever had complications from an extraction? YES NO
9. Have you ever had popping or clicking near your ear when you chew? YES NO
10. Are you prone to frequent headaches? YES NO
11. Do you grind or clench your teeth? YES NO
12. Do you have sores, blister or swelling on your gums, lips or cheeks? YES NO
13. Have you ever had orthotic treatment? YES NO
14. Do you snore? YES NO

15. Do you have problems with bad breath? YES NO
16. Have you ever had an allergic reaction to a crown, metal filling or dental appliance? YES NO
17. Have you ever used an electric toothbrush? YES NO
18. Are your teeth sensitive to hot, cold or pressure? YES NO
19. Do you like the appearance of your smile? YES NO
20. On a scale of 1-10, with 10 being the highest, how important is your dental health to you? _____

21. If you could change something about your smiles what would it be?
 - WHITER
 - STRAIGHTEN
 - CLOSE SPACE
 - REPAIR CHIPPED TOOTH
 - REPLACE MISSING TEETH
 - REPLACE OLD CROWNS THAT DONE MATCH
 - REPLACE OLD BLACK MERCURY FILLINGS
 - OTHER: _____

