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:** _____

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HEALTH QUESTIONAIRE

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 HOSPITILIZED?
   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

JOINT CONDITION

ARTHRITIS……..……..…… ☐ YES ☐ NO

ARTIFICIAL KNEE REPLACEMENT…..…… ☐ YES ☐ NO

ARTIFICIAL HIP REPLACEMENT……..…… ☐ YES ☐ NO

SWOLLEN ANKLES……..…… ☐ YES ☐ NO

OTHER: _____

CANCER

LOCATION: _____

SURGERY……...…… ☐ YES ☐ NO

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

ANTIOCOAGULANTS..... ☐ 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: _____

<u>WOMEN ONLY</u>

ARE YOU TAKING BIRTH CONTROL? ..... ☐ YES ☐ NO

ARE YOU PREGNANT? ..... ☐ YES ☐ NO

ARE YOU NURSING/BREASFEEDING? ..... ☐ YES ☐ NO

NOTE: ANTIOBIOTICS (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.

COMMINTMENT TO APPOINMTENT 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 your 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. Pleas 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

WILSHIRE SMILE STUDIO

the multi-specialty dental group

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**

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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:** _____