Our Commitment to You

We would like to take this opportunity to thank you for being an important member of our dental practice and to assure you of our continued commitment to excellence in providing dental care for you and your family. We appreciate your understanding in our efforts to maintain respectful guidelines for our practice to keep the caliber of care and service extraordinary.

Treatment
Our goal is to build a long-term relationship with you and to help you in a relaxed and friendly environment. We are committed to providing you with a thorough and complete understanding of your dental condition, so that you can make an informed decision about your treatment. We want to assure you we will be with you every step of the way and welcome any questions you may have.

By initialing this section and signing below, you indicate that you understand and agree to these treatment guidelines. ***Initial_____***

Financial Arrangements
Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are available to answer your questions and assist you in any way we can. We happily accept cash, credit cards (VISA, MasterCard, Discover and American Express). All financial arrangements must be made in advance with a member of our team. Please be prepared to pay any estimated patient portion co-pays at the time treatment is discussed.

I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at time of services unless other arrangements have been made previously. In the event that payments are not made by me or my insurance company on time, I will be held responsible, and a 5% per month late fee shall automatically be added to my account after the account has aged over ninety (90) days.

By initialing this section and signing below, you indicate that you understand and agree to these financial guidelines. ***Initial_____***

Insurance
We are pleased that you have dental insurance to help you with partial assistance in affording your dental care. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- Insurance is an agreement between you and your insurance company. The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy.

Sepideh Najaran, D.M.D. | Mary Grace Samonte-Mora, D.D.S.

16100 Sand Canyon Ave. Suite 270 Irvine, California 92618
phone: 949.727.9077 | fax: 949.727.9094
www.sandcanyondentistry.com

- I agree to authorize assignment of benefits from the insurance company for payment directly to Sand Canyon Dental the expense benefits allowable and otherwise payable to me. This payment shall not exceed my indebtedness to above named assignee and I also agree to pay in a current manner. Any balance of said professional service charges over and above this payment. You will receive a summary of diagnosed treatment this will give you a good idea as to the condition of your mouth, and it will list the approximate costs of having the needed treatment completed. The final analysis and the exact costs will be based on the treatment that was actually completed and the fees routinely charged for such procedures.

By initialing this section and signing below, you indicate that you understand and agree to these insurance guidelines. ***Initial_____***

Appointments
We pre-plan and prepare for your visit and hope you have done the same. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. When time is lost due to last-minute changes, other patients in need of treatment cannot be seen and your treatment is delayed.

- Should any scheduling changes be required, we require at least 24 hours advance notice during our normal business hours (Monday-Thursday) to avoid a $75.00 rescheduling fee.

Courtesy Reminder Calls
We consider all appointments confirmed when they are made. As a courtesy, we make every effort to remind patients by telephone prior to their appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, cell phones, pagers, and voice mails, some of our patients may not receive these reminder calls.

- If we are unable to speak with you directly, your appointment card will serve as confirmation and implies your obligation to be present at that prearranged date and time.

By initialing this section and signing below, you indicate that you understand and agree to these appointment guidelines. ***Initial_____***

We appreciate your understanding in our efforts to provide you with a positive experience.

Patient Signature:_____

Guardian Signature:_____

Date:_____

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SAND CANYON DENTAL

Superior Cosmetic & Family Dental Care

PATIENT REGISTRATION

Welcome to our office! We are so glad you have chosen us to meet and exceed your dental expectations! Please take the time needed to complete our patient registration, especially the insurance information if you have not already given it to one of our staff members.

NAME:

Last_____First_____MI_____Preferred_____

Male_____Female_____Married_____Single_____Child_____Other_____

Birth Date_____Social Security No._____Driver's License No._____

Name of Responsible Party_____Relationship_____

ADDRESS:

Street_____Apartment No._____

City_____State_____Zip Code_____

Home Telephone No._____Employer _____Work Telephone No._____Ext._____

Pager/Cell No._____E-Mail_____

Emergency Contact_____Telephone No._____

INSURANCE INFORMATION:

Subscriber_____Birth Date_____

Social Security Number of Subscriber_____Policy No._____

Insurance Company Name_____Group No._____

Telephone No._____

Relationship to Subscriber:

Self_____Spouse_____Child_____Other_____

Employer for Subscriber_____

Who may we thank for referring you to our office? _____

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Patient's name_____

Patient's address_____

Medical Physician's name _____ Date of last visit _____

Emergency Contact _____Phone _____Relationship _____

Circle "Yes" or "No" to indicate if you have had any of the following:

AIDS	**yes**	**no**	Headaches	**yes**	**no**	Are you nursing?	**yes**	**no**
Anemia	**yes**	**no**	Heart Murmur	**yes**	**no**	Psychiatric Care	**yes**	**no**
Arthritis, Rheumatism	**yes**	**no**	Heart Problems	**yes**	**no**	Radiation treatment	**yes**	**no**
Artificial heart Valves	**yes**	**no**	Hepatitis	**yes**	**no**	Reactions to anesthetic	**yes**	**no**
Artificial Joints	**yes**	**no**	type	_____		Respiratory disease	**yes**	**no**
Asthma	**yes**	**no**	Herpes	**yes**	**no**	Rheumatic Fever	**yes**	**no**
Back Problems	**yes**	**no**	High Blood Pressure	**yes**	**no**	Scarlet Fever	**yes**	**no**
Bleeding abnormally extractions or surgery	**yes**	**no**	Hip/Joint Replacement	**yes**	**no**	Shortness of Breath	**yes**	**no**
Blood Disease	**yes**	**no**	HIV Positive	**yes**	**no**	Sinus Trouble	**yes**	**no**
Cancer	**yes**	**no**	Jaundice	**yes**	**no**	Skin Rash	**yes**	**no**
Chemical Dependency	**yes**	**no**	Jaw Pain	**yes**	**no**	Special Diet	**yes**	**no**
Chemotherapy	**yes**	**no**	Kidney Disease	**yes**	**no**	Stroke	**yes**	**no**
Circulatory Problems	**yes**	**no**	Liver Disease	**yes**	**no**	Swelling of feet or ankles	**yes**	**no**
Congenital Heart Lesions	**yes**	**no**	Low Blood Pressure	**yes**	**no**	Thyroid Problems	**yes**	**no**
Cortisone Treatments	**yes**	**no**	Mitral Valve Prolapse	**yes**	**no**	Tonsillitis	**yes**	**no**
Cough, persistent	**yes**	**no**	Nervousness	**yes**	**no**	Tuberculosis	**yes**	**no**
Or bloody	**yes**	**no**	Osteoporosis/Osteopenia	**yes**	**no**	Tumor growth on head	**yes**	**no**
Diabetes	**yes**	**no**	Pacemaker	**yes**	**no**	or neck	**yes**	**no**
Emphysema	**yes**	**no**	Pregnant?	**yes**	**no**	Ulcer	**yes**	**no**
Do you wear contact lenses?	**yes**	**no**	Due date	_____		Venereal Disease	**yes**	**no**
Epilepsy	**yes**	**no**				Weight loss unexplained	**yes**	**no**
Fainting/dizziness	**yes**	**no**						
Glaucoma	**yes**	**no**						

MEDICATIONS

List any medications you are Currently taking: _____

_____

_____

ALLERGIES

_____Aspirin ____Local Anesthetic

_____Codeine ____Barbituates

_____Sulfa ____Latex

_____Penicillin

Are you required to Pre-Med prior to dental appointments? Yes No

Do you use recreational drugs? Yes No Other_____

Have you ever taken Fen-Phen? Yes No Other _____

Do you have a history of taking bisphosphonates (Fosamax, Boniva, Didronel, Skelid, Aredia, and Zometa)? **yes** **no** If yes please circle: **IV** **Oral**

Patient's Signature_____Date_____

Parent's or responsible party if minor under 18 (printed name and signature) _____Date_____

Doctor's Signature _____*Date*_____

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Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy policies to gain a clear understanding of how we may use and disclose your PHI.

For Questions concerning our Notice of Privacy Policies, please contact:
Our Office by:
Phone: (949) 727-9077
Fax: (949) 727-9094
Email: info@sandcanyondentistry.com

Patient's Consent

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ E-Mail_____

I, _____, have read your Notice of Privacy Policies and Dental Material Fact Sheet and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

_____ _____
Patient Signature Date

If this consent is signed by a personal representative on behalf of the patient, or if the patient would like to give authorization for a personal representative to have access to their medical records please complete the following:

Personal Representative's Name:_____
Relationship to Patient: _____
Contact Information: _____
Address City State Zip

_____
Phone E-mail

_____ _____
Patient/Representative Signature Date

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