BOB DARDASHTI, D.D.S.

General & Cosmetic Dentistry

Confidential

Please Complete Fully and Clearly

Date_____
Patient Name_____ Home Phone_____ Cell_____
Address_____City_____State_____Zip_____
Sex: ___Birth Day: _____Age: ___Single: ____Married: ___Widowed: ___Divorced: _____
Employed By: _____Address: _____Business Phone: _____
Emergency Phone_____ Contact Person_____
Spouse Name: _____Spouse Birth date: _____ Responsible Party_____
Self-S.S.N# _____Spouse-S.S.N# _____CDL# _____Exp Date: ____
Dental Insurance Comp: _____Group Number: _____
How did you hear about this Dental Office? _____

Medical History

Please Answer All Questions

Physician's Name: _____ Phone # _____Last physical: _____
Please indicate if you have had any of the following? (Please Check all that apply): Yes or No

Y / N	Y / N	Y/ N
_ _ Heart Murmur	_ _ Epilepsy	_ _ Osteoporosis
_ _ High Blood Pressure	_ _ Headaches	_ _ Swollen glands
_ _ Low Blood Pressure	_ _ Hepatitis jaundice or Liver Disease	_ _ Rheumatic Fever
_ _ Circulatory Problems	_ _ Cancer	_ _ Sinus Problems
_ _ Nervous Problems	_ _ Have you been exposed to HIV/AIDS	_ _ Psychiatric Care
_ _ Radiation Treatment	_ _ Mitral Valve Prolapsed	_ _ Thyroid Disease
_ _ Artificial Valves or joints	_ _ Allergies to Anesthetics	_ _ Stroke
_ _ Recent Weight Gain or Loss	_ _ Allergies to Medicine or Drugs	_ _ Ulcer
_ _ Back Problems	_ _ General Allergies	_ _ Venereal Disease
_ _ Diabetes	_ _ Blood Disease	_ _ Chemical Dependency
_ _ Respiratory Disease	_ _ Arthritis	_ _ Hemophilia

Are you Allergic to latex Y_ N_ Have you ever taken Phen Phen Y_ N_ for how long _____
Do you have any drug allergies or had an adverse reaction to any medication? Y___ N___ If so, for what_____ _____
Are you taking any medications at this time? Y___ N___ If so, what_____
Are you under the care of a physician? _____For what conditions? _____
(Woman) are you pregnant? Y__ N__ Are you nursing? Y__ N__ Are you in good health? _____

In the event that x-rays becomes necessary I hereby authorize Doctor DARDASHTI D.D.S. to perform any and all treatment for child (if patient is minor) or myself. I also consent to such methods as X-rays, Drugs and Agents as may be indicated in connection with treatment. This consent will remain in effect until cancelled.
In the event that it is necessary for dentist to retain the services of an attorney to enforce payment by the undersigned, the undersigned agrees to pay in full in addition to all other sums due here all attorney's fees. Patient agrees to use an arbitrator.
On occasion, you may experience prolonged numbness (parasthesia) of the lips, skin and/or tongue after the injection of a local anesthetic. This should be transient and normal sensation should come back.
Please note; payment is expected for services at the time the treatment is rendered. All payments made will be applied to patient's co-payment if patient had insurance. Financial arrangements may be made following payment for diagnosis.

The above Medical History and Personal Information is accurate and true

Date_____ Signature_____ Doctor _____ Date_____

Treatment Consent

Please read the following sections and initial each section stating that it is understood.

___**WORK TO BE DONE** –I understand that in order for the Dentist to properly diagnose the treatment that I may need an examination and x-rays must be done first before any dental treatment.

___**CHANGES IN TREATMENT PLAN**- I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Dardashti to make any/all changes and additions as necessary, after informing me of said changes.

___**DRUGS AND MEDICATIONS** –I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and /or anaphylactic shock (severe allergic reaction where applies).

___**COMPLETE AND PARTIAL DENTURES**- I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, tooth placement and color) will be the "teeth "try-in" visit. I understand that most dentures require relining approximately 3-12 months after initial placement (When applies). The cost for this procedure is not included in the initial denture fee.

___**PERIODONTAL LOSS (TISSUE & BONE)** - I understand that I could have a serious condition that can cause gum infection that can lead to the loss of my teeth. If so, alternate treatment plans will be explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking some dental procedures may have a future adverse effect on my periodontal condition.

___ I understand that dentistry is not an exact science and that therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me.

Patient name: _____ Date_____

Signature of patient or parent: _____ Date_____

Doctor: _____ Date_____

BRIGHTER DENTAL
Making the world a brighter place one smile at a time.

6221 Wilshire Boulevard
Suite 507
Los Angeles, CA 90048
323 939 7899
323 939 6932 Fax
www.brighterdentalinc.com

Acknowledgement of receipt of privacy practices notice

Patient information

Name: _____
Address: _____
Telephone: _____
E-mail: _____

I, _____, acknowledge that I have received and had an opportunity to read and review the notice of privacy practices of Brighter Dental.

(The notice, on Privacy Practices of Brighter Dental is posted in the waiting room, copies are available upon request.)

Signature of the patient or guardian: _____

Relationship to the patient if a guardian: _____

Patient Acknowledgment of
Receipt of Dental Materials Fact Sheet

I,_____, acknowledge I have
patient name

received from **BRIGHTER DENTAL** a copy of the
Dental office name

Dental Materials Fact Sheet dated October 17, 2001.

_____ _____
Patient Signature *Date*

A complete copy of this notice is available to you upon your request.

The introductory prevision of the Dental Materials Fact Sheet is reprinted below for reference purposes only.

The following document is the Dental Board of Caiifornia's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet; and its linkage to the DCA web site does not constitute an endorsement of the content of this document

The Dental Board of California
Dental Materials Fact Sheet
Adopted by the Board on October 17, 2001
As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.
The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." A Glossary of Terms" is also attached to assist the reader in understanding the terms used.
The statements made are supported by relevant, credible dental research published mainly between 1993 - 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.
The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the matenal from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Brighter Dental
Dr. Bob Dardashti
6221 Wilshire Boulevard #507
Los Angeles, CA 90048

Acknowledgement of receipt of non-refundable treatment(s)

This notice is to inform the patient that once Doctor Dardashti has started a treatment for:

- Invisalign
- Root canals
- Crowns
- Bridges
- Bonding
- Partial's
- Denture's

And any other treatment's rendered with follow-up appointments so work can be completed will not be refunded once treatment begins.

Failed appointments are patient's responsibility to reschedule so work is completed, if patient does not reschedule appointment (s) in a timely fashion and treatment is altered due to time lapse then it is patient's responsibility to any additional charges.

_____

Patient signature

Thank you
Dr. Bob Dardashti