smile essentials

Welcome to Our Practice!

On behalf of our staff, we welcome you to our office. We are pleased that you have selected us to care for your dental needs and we look forward to your initial visit.

We want you to know that we are committed to providing you with the highest quality of oral health care in the most gentle, efficient and enthusiastic manner possible. We pride ourselves on making dentistry a pleasant experience for you, while providing you with the best dental treatment.

Our emphasis is on early preventive care, but we also provide restorative care, including full mouth rehabilitation and emergency services. Our primary goal, whenever possible, is the retention of your healthy, natural teeth. With this in mind, let me tell you what you can expect on your first visit to our office.

During your first visit a comprehensive examination will be completed. This exam will include necessary x-rays allowing us to diagnose the condition of your mouth, teeth, and gums. In most instances, your dental condition will be determined at this visit and if needed, a suitable treatment plan will be discussed with you.

We appreciate the value of your time, and expectations, you can expect us to be on time for you. We will appreciate the same courtesy. We expect at least 24-hour advance notice for appointment cancellation to allow us to schedule your reserved time to another patient in need.

If you have dental insurance, please bring your insurance card and your dental benefits booklet if one has been distributed. If a card is not available please have all insurance information, such as provider name, address, subscriber 10 number, etc.

Should you have any questions about our practice, services, or policies please do not hesitate to contact our office or visit our website at **www.SMESdental.com**. Our new patient registration forms are available on our website to download and fill out prior to your initial visit. If you don't have access to the internet or a printer, please arrive 15 minutes before your scheduled appointment to complete registration forms. We look forward to your visit!

Warmest regards,

Megan Arjmandi

Megan Arjmandi DDS

P | 760.659.3452
F | 760.806.5307

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Patient Name _____ **DOB** _____ **Today's Date** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Work** _____ **Social Security #** _____ **Sex** Male Female

Marital Status Married Single Divorced Widow **Email** _____

Employment Status Full Time Part Time Student Retired **Employer/School** _____

Emergency Contact _____ **Phone #** _____

M.D.'s Name and Contact # _____

Whom may we thank for referring you? _____

Primary Insured Members Name _____ **Relationship to Insured** _____

DOB of insured _____ **Insured's ID #** _____ **Social Security #** _____

Insurance Company _____ **Employer** _____

Group # _____ **Contact #** _____

Secondary Insured Members Name _____ **Relationship to Insured** _____

Date of Birth of insured _____ **Insured's ID #** _____

Social Security # _____

Insurance Company _____ **Employer** _____

Group # _____ **Contact #** _____

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Medical History Form

Patient's Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you are taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Sulfa

❑ Other (Please explain) _____

❑ Are you under a physician's care now? If yes, please explain _____

❑ Have you ever been hospitalized or had a major operation? If yes, please explain _____

❑ Have you ever had a serious head or neck injury? If yes, please explain _____

❑ Are you taking any medications, pills, or drugs? If yes, please explain _____

❑ Do you take, or have you taken, Phen-fens or Redux?

❑ Are you on a special diet?

❑ Do you use tobacco?

❑ Do you use controlled substances?

❑ Do you or have you been taking bisphosphonates?
[fo50max, Boniva, Zornera, Actone], Reclast, Aredia, Oidronel or Skelidj

If yes, what is the medication for and how long?

_____

Women Only

❑ Are you pregnant / trying to get pregnant?

❑ Taking oral contraceptives?

❑ Nursing?

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Medical History Form

Do you have, or have you had, any of the following? ❑ Yes ❑ No

- ❑ AI DS/H IV Positive
- ❑ Alzheimer's. Disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis / Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cancer
- ❑ Cold Sores / Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy/seizure
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells / Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Frequent earaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack Failure
- ❑ Heart Murmur
- ❑ Heart Pace Maker
- ❑ Heart Trouble / Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lyme Disease
- ❑ Mitral valve Prolapse
- ❑ Multiple Myeloma
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatry Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/ Intestinal
- ❑ Stroke
- ❑ Swelling
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

Have you ever had any other sickness or injury not listed above?

Please explain _____

Comments _____

_____

_____

Patient / Parent / Guardian Signature _____

Date _____

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Dental Health History Form

Patient's Name

First _____ MI _____ Last _____ Nickname _____

Address

Street _____ City _____ State _____ Zip _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past? _____

Date of last radiographs (x-rays) and exam _____

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance) _____

Former Dentist _____ Phone _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? ❑ Yes ❑ No If yes, please explain _____

Have you ever been pre-medicated for dental treatment? ❑ Yes ❑ No If yes, why? _____

Have you been anxious about having dental treatment? ❑ Yes ❑ No

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? ❑ Yes ❑ No

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Dental Health History Form

What concerns do you currently have with your oral health or smile? (check all that apply)

- ❑ Jaw joint pain
- ❑ Clenching or grinding of teeth
- ❑ Discolored teeth
- ❑ Crowding/Crooked teeth
- ❑ Missing teeth
- ❑ Spaces in between teeth
- ❑ Loose tooth/teeth
- ❑ Tooth shape or size
- ❑ Unhappy with appearance of teeth
- ❑ Overbite
- ❑ Underbite
- ❑ Uncomfortable bite
- ❑ Old fillings (gold or silver}
- ❑ Old crowns
- ❑ Speech problems
- ❑ Too much gum tissue when I smile
- ❑ Tooth sensitivity to hot/cold or anything else
- ❑ Food gets caught in between teeth
- ❑ Difficulty chewing
- ❑ Bad breath
- ❑ Other _____
- ❑ None

Have you ever had orthodontic treatment? ❑ Yes ❑ No If yes, when? _____

Have you ever had periodontal (gum tissue) treatment,
such as deep cleanings, root planing, or periodontal surgery? ❑ Yes ❑ No

If yes, when? _____

Have you whitened your teeth in the past? ❑ Yes ❑ No If yes, what method? _____

Are you interested in learning more about the following? (check all that apply)

- ❑ Teeth Whitening
- ❑ Orthodontic treatment
- ❑ Veneers
- ❑ Tooth-colored fillings
- ❑ Dental implants
- ❑ How to prevent periodontal disease
- ❑ At-home oral hygiene care
- ❑ Periodontal treatment during pregnancy
- ❑ Oral hygiene care for infants and toddlers
- ❑ None

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Appointments and Cancellations

When we make your appointment, we are reserving a room for your needs. We ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a charge for not showing up for this schedule appointment which may be up to $50. Repeated late cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt and ready for your visit. We, of course, would appreciate the same courtesy from you!

By signing this form you're accepting the terms and conditions within this document. If you have any questions, please feel free to contact our staff at 760-806-5302, or through email at: office@smesdental.com.

Please sign below to consent to these terms.

Patients signature (Client's Parent/Guardian if under 18) _____ Date _____

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Patient's Name _____ **DOB** _____

Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____ Relationship to Patient _____

Emailing X-rays

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service. I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

You are entitled to a copy of this consent after you sign it.

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Dental Practice Covered by this Notice

This Notice describes the privacy practices of Smile Essentials Dental Care ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

1. How to Contact Us / Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Smile Essentials Dental Care's Privacy Official at 760.806.5302 and ask for Dr. Arjmandi.

2. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information.
- Give you this notice of our legal duties and privacy practices with respect to that information.
- Abide by the terms of our notice that is currently in effect including disability ; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods ; reporting product defects ; enabling product recalls ; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence

We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities

We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions

We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

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6. Law Enforcement Purposes
We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors
We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation
We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes
We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety
We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions
We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation
We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review
You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend
If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you payout of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment. health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information. The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this H IPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice.

How to Make Privacy Complaint

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.