

Dr. Alireza Panahpour

Doctor of Dental Surgery
2701 Ocean Park Blvd #108
Santra Monica, CA 90405
(888) 338-6336 (office)
(888) 338-6336 (fax)
www.AlternativeDental.com

NAME: Last, First, Middle		<input type="checkbox"/> Male <input type="checkbox"/> Female	TODAY'S DATE:
ADDRESS: Street or P.O. Box		City	State Zip
PHONE NUMBERS: Home		Cellular	Fax
AGE:	BIRTH DATE:	<input type="checkbox"/> Single <input type="checkbox"/> Married	SOCIAL SECURITY NO:
OCCUPATION:	EMPLOYER:		PHONE NUMBER:
ADDRESS: Street or P.O. Box		City	State Zip
SPOUSE OR PARENT:		BIRTH DATE:	SOCIAL SECURITY NO:
OCCUPATION:	EMPLOYER:		PHONE NUMBER:
INSURED PERSON'S FULL NAME:		BIRTH DATE:	SOCIAL SECURITY NO:
EMPLOYER'S NAME:	PHONE NUMBER:	INSURANCE COMPANY:	
GROUP NAME:	GROUP NUMBER:	INSURANCE COMPANY NUMBER:	
DO YOU HAVE OTHER DENTAL INSURANCE? IF SO, WHAT IS THE NAME OF THE COMPANY, GROUP NO, NAME OF INSURED?			
IN CASE OF EMERGENCY:		ADDRESS:	
PHONE NUMBERS: Home Cellular	RELATIONSHIP TO PATIENT:		

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Whom may we thank for referring you? _____

Are any of your friends or family members patients of Dr. Pana? _____

Why did you select our practice? _____

Payment Alternatives

In order to keep procedure costs at a minimum, payment is due at the time of service. We will electronically bill your insurance company as a service to you. A reimbursement from your insurance provider may be applicable for some procedures. This reimbursement typically takes two weeks for the insurance company to process, and will be mailed to you upon completion. As a courtesy, Dr. Pana offers a few payment options.

Please check the appropriate box:

- 5% discount for payment for your entire treatment, prior to the procedure appointment. (Cash and personal checks will be accepted for this courtesy).
- Visa, MasterCard, American Express, and Discover
- 3 payments over 60 days (50% of the treatment cost at the initial appt., 25% 30 days from the initial appt., and 25% 60 days from the initial appt. Treatment must exceed \$300.)
- For long term or extended payments, we offer a healthcare financing program. (Upon approval, monthly payments can be made to the credit agency. Some programs are interest free, while longer term financing involves an interest rate.)

For All Patients

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, the doctor and/or his staff will give a full explanation of the procedure(s) involved. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminder items sent via mail or email. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in the office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP

DATE

MEDICAL/DENTAL HISTORY

- 1) Do you presently have or have you had pain or discomfort in the mouth, face, or jaws? YES NO
- 2) Do your gums bleed at any time? YES NO
- 3) Do you have aching or sensitive teeth? YES NO
- 4) Have you had an injury to your face or jaw? YES NO
- 5) Have you had serious trouble associated with any previous dental treatment? YES NO
- 6) Do you feel nervous or uneasy about having dental treatment? YES NO

7) Date of last dental treatment was: _____

8) My main reason for coming today is: _____

(CONTINUED ON NEXT PAGE)

Patient's Name: _____

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MEDICAL/DENTAL HISTORY CONTINUED...

- 9) Have you been a patient in a hospital during the past two years? YES NO
If yes, for what reason? _____
- 10) Have you been under the care of a medical doctor during the past two years? YES NO
If yes, for what reason? _____
- 11) Do you use tobacco products? YES NO
- 12) Do you drink alcoholic beverages? YES NO
If yes, please list how many per week, e.g., 1-2 drinks/week: _____
- 13) Do you use recreational or street drugs? YES NO
- 14) Are you currently taking, or have you taken within the past two years, any prescription or non-prescription drugs? **If so, please list here:**

DRUG

DOSE/FREQUENCY

REASON FOR TAKING

- 15) Do you have any allergies (i.e., itching, rash, swelling, of hands, eyes, or feet), or are you made sick by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, or medications? YES NO
If yes, allergic to what? _____
- 16) Have you ever had excessive bleeding requiring special treatment? YES NO
- 17) When you walk upstairs or take a walk, do you ever have to stop because of chest pain? YES NO
- 18) Do your ankles swell during the day? YES NO
- 19) Do you use more than two pillows to sleep? YES NO
- 20) Have you lost or gained more than 10 pounds in the last year? YES NO
- 21) Do you wake up short of breath? YES NO
- 22) Are you on a special diet? YES NO
- 23) Women: Are you pregnant now? YES NO
Are you currently using a prescription-type contraceptive? YES NO
- 24) Check any of the following which you have had or have at present:

Heart Failure

Kidney Disease or Dialysis

Rheumatism

Heart Disease or Attack

Stomach Problems or Ulcers

Cortisone Medication

Angina Pectoris (chest pain)

Cancer

Glaucoma

(CONTINUED ON NEXT PAGE)

Patient's Name: _____

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MEDICAL/DENTAL HISTORY CONTINUED...

- | | | |
|--|--|---|
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Tumor | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> AIDS or HIV antibody |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Fast, Irregular Heartbeat | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia or Anemia |
| <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Depression |

- 26) Do you snore, clench, or grind your teeth? YES NO
- 27) Do you suffer from headaches or migraines? YES NO
- 28) Does your jaw click when you open your mouth? YES NO
- 29) Do you have difficulty opening your mouth completely? YES NO
- 30) Have you previously had orthodontic treatment? YES NO
- 31) Do you wear a retainer? YES NO
- 32) Do you medicate before dental treatment? YES NO
- 33) Do you have history of any genetic, congenital, or family-type disorder? YES NO
- 34) Do you have any disease, condition, or problem not listed? YES NO

If yes, please describe here: _____

35) How do you feel about maintaining a healthy mouth? _____

36) How do you feel about the appearance of your teeth? _____

37) If you could change anything about your smile, what would you change? _____

To the best of my knowledge, all of the preceding health and dental history answers are true and correct.

Signature: _____ Date: _____

Print: _____ Relationship to Patient: _____

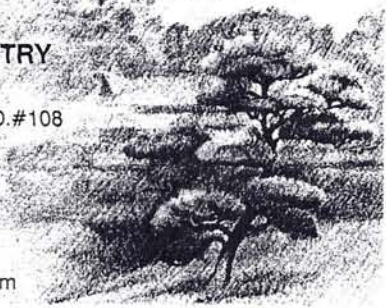
ALIREZA PANAHOUPOR DDS INC

SYSTEMIC DENTISTRY

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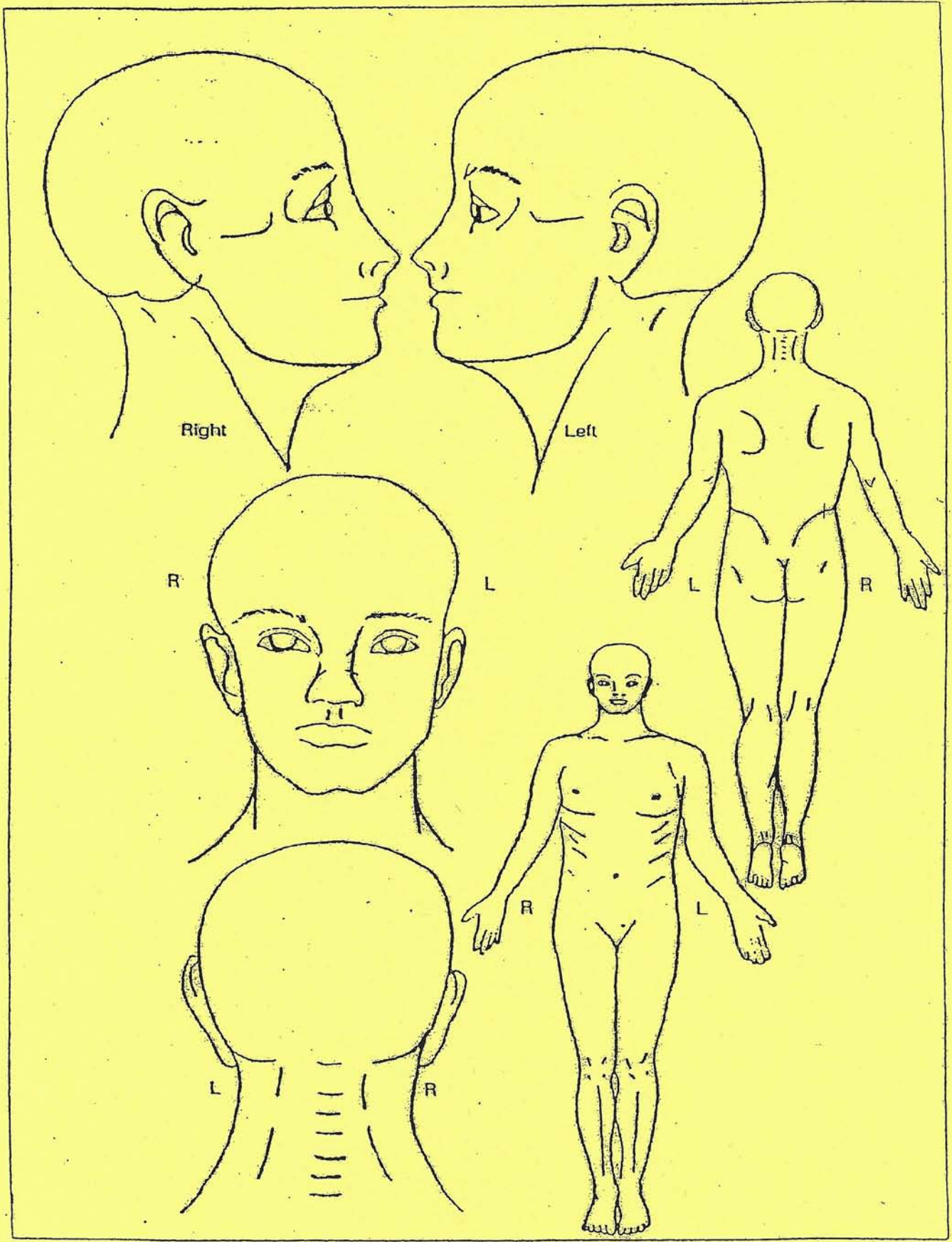
CONSENT AND AGREEMENT

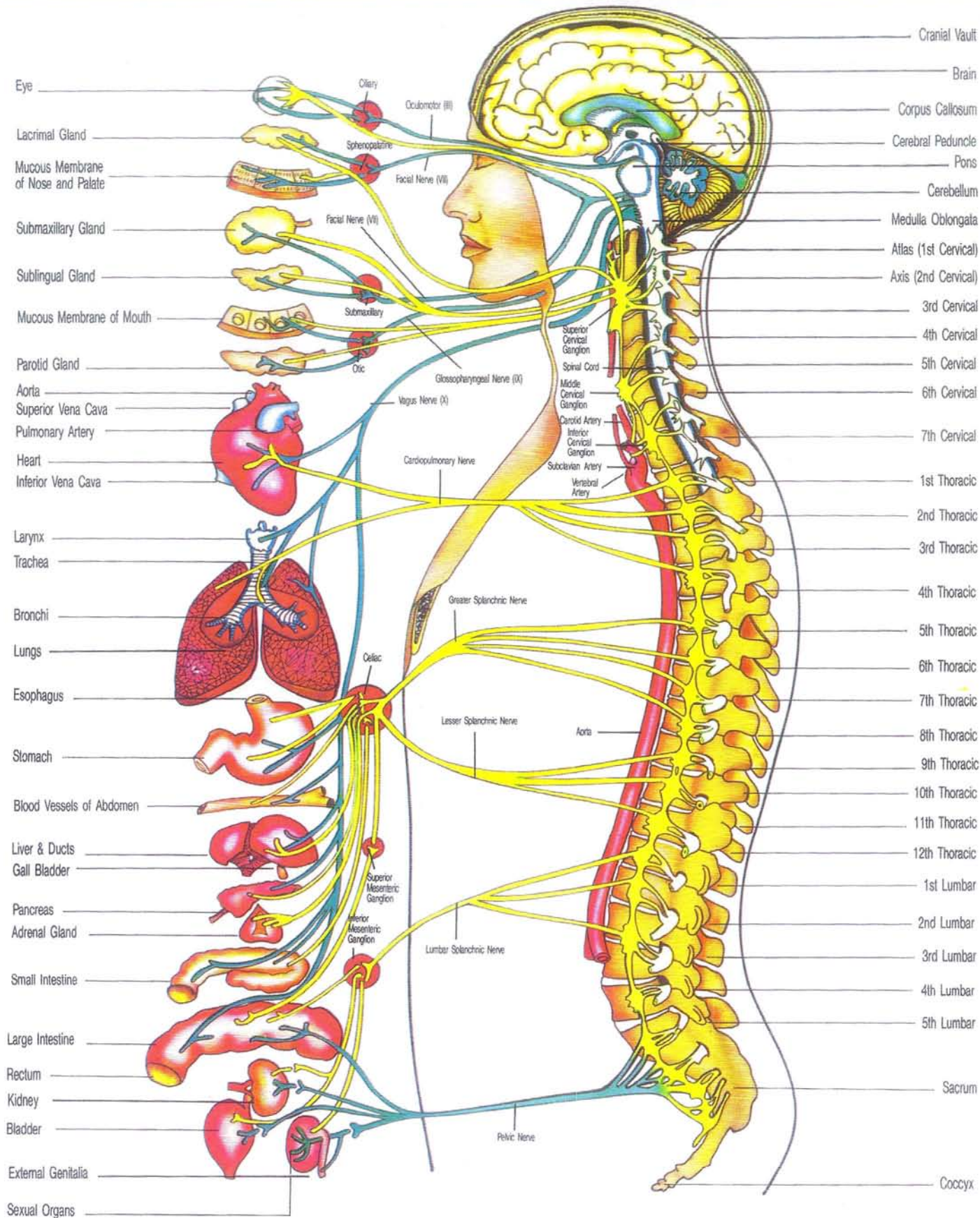
1. I Hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my (or patient's) dental needs.
2. Upon such diagnosis, I authorize doctor or designated staff to perform all recommended treatment, mutually agreed upon, and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
4. I understand that if I cancel an appointment with less than 24 hours notice, or fail to show for an appointment, I will be charged a fee of 30% of the cost of the scheduled procedure for any procedures totaling a minimum of \$200. If I am late more than 15 minutes my appointment will be reschedule.
5. I agree to be responsible for payment of all services rendered on my or my dependents behalf. I understand that payment is due at the time of services unless other arrangements have been made beforehand. I understand that a 1.5% monthly finance charge (18.0% APR) plus the costs of any necessary collection fees may be added to my account.

Patient Name: _____

Patient Signature: _____

Date: _____





AUTONOMIC NERVOUS SYSTEM

Sympathetic – Yellow Parasympathetic – Blue

For simplicity, this chart does not reflect all the paths of nerve transmission. Ask your chiropractor if you have any questions.