



DR. ALIREZA PANAHPOUR, DDS, INC.
2701 OCEAN PARK BLVD #108
SANTA MONICA, CA 90408
(888) 338-6336

www.AlternativeDental.com

Dear Patient,

Welcome! Your commitment to your own well being has brought you to Dr. Alireza Panahpour, DDS, Inc. We are delighted to be of service to you.

You may have been on a long and arduous journey of seeking help and we would like to assure you that you have reached your destination.

Dr. Alireza Panahpour, DDS, Inc. is more than a dental practice. Dr. Pana practices Whole Life Health that grows from the philosophy that all aspects of life are connected in a most miraculous way. Along with his Doctor of Dental Surgery degree, Dr. Pana studied Western Medicine as well as the natural healing arts, working with some of the esteemed doctors and healers worldwide.

We are committed to providing you with the most advanced and effective healing modalities possible. We use the highest quality products and therapies, including natural herbal and homeopathic remedies and ultra low-dose imaging instead of traditional x-rays.

Due to our eclectic variety of treatment and homeopathic care we expect your curiosity and questions. Please feel free to ask us anything you deem necessary in order to better understand and be a partner in your healing process. In fact, we encourage it!

Our staff is here to provide excellent service. We appreciate and respect your trust in us. We promise to provide you with excellent, compassionate care.

Sincerely,

Dr. Alireza Panahpour, DDS, Inc.



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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., 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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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:		BIRTHDATE:		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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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?
- 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 are you made sick by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, medication?) 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Stomach Problems or
Ulcers | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina Pectoris (chest
pain) | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Congenital Heart
Lesions |
| <input type="checkbox"/> Kidney Disease or
Dialysis | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Scarlet Fever |
| | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Artificial Heart Valve |
| | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Heart Pacemaker |



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

- 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: _____



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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 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 72 hours notice, or fail to show for an appointment, I will be charged a fee of 30% of the cost of the schedule procedure for any procedures totaling a minimum of \$200. If I am late more than 15 minutes my appointment will be rescheduled.
5. I agree to be responsible for payment of all services rendered on my or my dependent's 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: _____