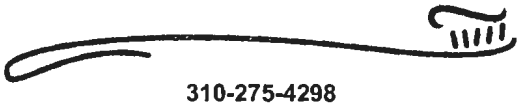
RACHEL MARMOR, D.M.D.

General And Cosmetic Dentistry



310-275-4298

6310 San Vicente Blvd., Suite 295 • Los Angeles, California 90048
www.beverlyhillscosmeticdds.com

PATIENT INTRODUCTION & HEALTH HISTORY

DATE _____

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program. In order to do this we must know as much about you as we do about your teeth. ALL INFORMATION, OF COURSE, WILL BE HELD IN STRICT CONFIDENCE.

PATIENT

Name_____ Email_____

If child: Parent's Name_____ Cell Phone_____

Date of Birth_____ Age_____ Home Phone_____

Address_____ City_____ Zip Code_____

Employed by_____ Position_____ Business Phone_____

Business Address_____ City_____ Zip Code_____

S/S # _____ D/L # _____

SPOUSE

Name_____

Employed by_____ Position_____ Business Phone_____

Business Address_____ City_____Zip Code_____

Convenient Appointment Time_____

Are you available for appointments on short notice?_____

Is another member of your family or relative a patient at our office? _____

In case of emergency, who should be notified?_____ Phone_____

DENTAL INSURANCE

Name of Insured _____ Employer_____

I.D. or S/S # of Insured _____ Birthdate_____ Relationship_____

Insured Co._____ Group/Plan No._____ Effective Date_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

DO YOU HAVE, OR DID YOU EVER HAVE, ANY OF THE FOLLOWING?

Cardiovascular:

YES/NO

- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ High blood pressure
- ☐ ☐ Heart disease from childhood
- ☐ ☐ Heart murmur
- ☐ ☐ Rheumatic fever
- ☐ ☐ Use of Phen-Fen
- ☐ ☐ Pacemaker
- ☐ ☐ Vascular graft
- ☐ ☐ Heart valve replacement
- ☐ ☐ Heart attack
- ☐ ☐ Heart surgery
- ☐ ☐ Congestive heart failure
- ☐ ☐ Angina (chest pain)
- ☐ ☐ Irregular heart beat
- ☐ ☐ Stroke
- ☐ ☐ Increased cholesterol

Respiratory:

YES/NO

- ☐ ☐ Asthma
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis
- ☐ ☐ Other_____

Endocrine/Hematologic/ Oncologic/Immune:

YES/NO

- ☐ ☐ Diabetes
- ☐ ☐ Thyroid disease
- ☐ ☐ Hemophilia
- ☐ ☐ Sickle cell disease
- ☐ ☐ Bleeding tendency
- ☐ ☐ Anemia
- ☐ ☐ Cancer
- ☐ ☐ Radiation therapy
- ☐ ☐ Chemotherapy
- ☐ ☐ HIV infection/AIDS
- ☐ ☐ Organ transplant
- ☐ ☐ Blood transfusion

GI/GU:

YES/NO

- ☐ ☐ Hepatitis (A,B,C, or other?)
- ☐ ☐ Kidney dialysis
- ☐ ☐ Ulcers
- ☐ ☐ Sexually transmitted disease
- ☐ ☐ Denied permission to give blood

Musculo-Skeletal/CNS/ Development:

YES/NO

- ☐ ☐ Joint replacement
- ☐ ☐ Osteoarthritis
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Spinal cord injury
- ☐ ☐ Seizures
- ☐ ☐ Cerebral palsy
- ☐ ☐ Dementia

Psychological:

YES/NO

- ☐ ☐ Anxiety/Nervousness
- ☐ ☐ Depression
- ☐ ☐ Mental health treatment
- ☐ ☐ Eating disorder

Social:

YES/NO

- ☐ ☐ Do you use tobacco products?
- ☐ ☐ Do you drink alcohol?
- ☐ ☐ Every day? If so, how much?_____
- ☐ ☐ Do you use recreational drugs?

1. Are you allergic to: ___Penicillin ___Codeine ___Novocaine ___Aspirin ___Sulfa ___Latex ___Other_____
2. Presently taking medication?_____Please list:_____
3. Date of last physical exam_____
4. Are you now under the care of a physician?_____if so for what condition_____
5. Name of physician_____Phone_____
6. Do you smoke?_____
7. Have you had any serious illness or operation_____if so what_____
8. Any other disease or condition not listed_____
9. Woman Are you pregnant?_____Are you breast feeding now?_____ Are you taking birth control pills?_____
10. Have you ever been premedicated with antibiotics for dental treatment?_____

DENTAL HISTORY

What concerns you most?_____

Are you having discomfort at this time?_____What is the discomfort?_____

How long since you have been to a dentist?_____What was done then?_____

Did you have X-Rays?_____How often did you visit a dentist before then?_____

Have you lost any teeth?_____ Any complications with extractions?_____

Are your teeth sensitive to: heat_____ cold_____ sweets_____ sour_____

Have you ever had your teeth straightened?_____ When?_____

How often do you brush your teeth ?_____ Do you use dental floss?_____

Do you have bleeding gums?_____ Where?_____

Have you ever had gum treatment?_____ When?_____

Does food wedge between your teeth?_____ Where?_____

Do you grind or clench your teeth?_____ When?_____

Do you have any pain around your ear?_____ Do you hear popping or clicking noises when you chew?_____

Any swelling or lump in your mouth?_____

Do you have any fear of having dentistry done?_____

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

To the best of my knowledge all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. I am directly and fully responsible for payment submitted by doctor for services rendered. If this account is assigned for collection and/or suit, collection cost and interest and/or Attorney fee and court costs will be added to the amount due. Any returned check will incur bank fees.

I hereby authorize Dr. Danny Shiri to perform any and all treatment for myself or child (if patient is a minor). I also consent to such methods, X-rays, drugs, and agents as may be indicated in the connection with treatment. This consent will remain in effect until cancelled.

Signature of Patient or Guardian _____ Date_____

DANNY SHIRI, D.D.S.
RACHEL MARMOR, D.M.D

6310 San Vicente Blvd, Suite 295
Los Angeles, CA 90048
(323) 935-9102-Ph
(323) 935-1939-Fax

OFFICE POLICY

APPOINTMENTS

It is our goal in this office to give you, as our patient, the best care and treatment possible. Your appointment time is reserved especially for you. If for some reason you are unable to keep this time, Dr. Shiri appreciates as much notice as possible. Should you need to reschedule your appointment, **cancellation notice given less than 24-hours may be subject to a "Late Cancellation Fee".** The amount could vary depending upon how much time has been reserved for you. Missed appointments without notice will be charged. True emergencies will be taken into consideration and would be exempt from this policy.

_____
Initials

FINANCIAL ARRANGEMENTS

Full payment for treatment is due at the time services are rendered, unless **prior financial arrangements** have been agreed upon. Total fees are the patient's (or parent/guardian) responsibility.

_____
Initial

DENTAL INSURANCE

As a courtesy to you as our patient, our office will bill all insurance plans and do our best to maximize your annual benefits. Every policy varies in the amount allowed and/or paid for treatment. **It is the patient's responsibility as the policyholder to know exactly what your plan will cover for each service, and when your annual maximum expires.** We will be happy to assist you in this process.

_____
Initials

I have read and understand the above policy and I accept financial responsibility.

_____ _____
Patient/Guardian Signature Date

Rachel Marmor

DANNY SHIRI, D.D.S.
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: