Nader Ahdout, D.D.S Inc.
818.340.3062
www.smilescreator.com

WE ARE COMPLIMENTED THAT YOU HAVE SELECTED US TO PROVIDE DENTAL CARE FOR YOU AND OR YOUR FAMILY.
Whom may we thank for referring you to our office? _____

Patient's Information:

Date: _____ Patient's Name: _____
Address: _____
Home Ph. # ( )_____ Work Ph. # ( )_____
Cell. # ( ) _____ Email: _____
How would you like to be contacted? HM / Wk /Cell / Email If Cell.. Text or Voice Message
Birth date _____ Soc.Sec. # _____ Sex F/M
Employer _____ Occupation_____
Emergency Contact Name: _____ Phone # ( )_____

Insurance Information:

Subscriber's Name _____ Subscriber's Soc. Sec. # _____
Subscriber's Date of Birth _____ Relationship to patient_____
Insurance Company _____ Insurance Ph. # ( ) _____
Do you have a dual coverage? Y/N If yes: Please complete the following information:
Name _____ Subscriber's Soc. Sec. # _____
Subscriber's Date of Birth _____ Relationship to patient_____
Insurance Company _____ Insurance Ph. # ( )_____
Subscriber's Employer Name _____

Dental Information:

What is the reason for your visit today? _____
Last Dental cleaning _____ Last x-rays_____
Do your gums bleed? Y/N Are your teeth sensitive to heat or cold? Y/N
Do you grind or clench your teeth? Y/N Have you ever had gum treatment? Y/N
Are you satisfied with your teeth's appearance? Y/N Why? _____
Do you feel nervous about having dental treatment? Y/N Why? _____
Is there anything else about having dental treatment that you would like us to know? Y/N - If yes, please describe_____

Please complete next 6 pages, Thanks

1. Are you having pain or discomfort at this time? ..... Yes / No
2. Have you been a patient in the hospital during the last two years? ..... Yes / No
3. Are you now taking any medications or drugs? ..... Yes / No
4. Have you taken any medications or drugs during the last two years including appetite suppressants – fen-phen (fenturamine & Phentermine) or dexfenfluramine or fenflurameine or any medications to prevent Osteoporosis (E.G. (Boniva, Physomax, Actonel)? .....Yes / No
5. Have you been under the care of a medical doctor during the last 2 yrs.? .....Yes / No
   Physician's Name _____ _____ Ph. # ( ) _____
   Address_____
6. Are you sensitive or allergic to any medication or anesthetics? .....Yes / No
   If yes, please list: _____
7. Indicate which of the following you have had or have at the present. Circle "Yes or No" to each item:

Heart Problems.....Y / N	Artificial Heart Valve .....Y / N	Rheumatism.....Y / N	Hepatitis A or B (infectious) ..... Y / N
Heart Disease or Attack.....Y / N	Sinus Trouble ..... Y / N	Arthritis ..... Y / N	Allergy to Latex/Metal ..... Y/N
Angina Pectoris .... Y / N	Hay Fever ..... Y / N	Yellow Jaundice .....Y / N	Kidney Trouble ..... Y/N
Congenital Heart Disease..... Y / N	Artificial joints (hip, knee) . Y/N	Liver Disease ....Y / N	A. I. D. S. ..... Y / N
Heart Surgery ..... Y / N	High Blood Pressure..... Y / N	Allergies or Hives ..... Y/N	H. I. V. Positive ..... Y / N
Mitral Valve prolapse..... Y/N	Blood transfusion..... Y/N	Rheumatic Fever .....Y / N	Arteriosclerosis ..... Y / N
Glaucoma ....Y / N	Tuberculosis ..... Y/N	Cortisone Medicine .....Y / N	Emphysema ..... Y / N
Cancer ..... Y / N	Bruise Easily .....Y / N	Radiation Therapy..... Y / N	Hemophilia ..... Y / N
Fainting or Dizzy Spells. .....Y / N	Venereal Disease .....Y / N	Stroke ..... Y / N	Anemia ..... Y / N
Thyroid problems ..... Y/N	Cold sores/Fever blisters.... Y/N	Chemotherapy ..... Y / N	Sickle Cell Disease ..... Y / N
Nervousness.....Y / N	Chronic cough ..... Y/N	Drug Addiction ..... Y / N	Epilepsy or Seizures..... Y/N
Diabetes ..... Y/N	Ulcers or Tumors ..... Y/N	Hemophilia ..... Y/N	Asthma ..... Y/N

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest? Shortness of breath/tired.....Y/N
9. Do your ankles swell during the day? ..... Yes / No
10. Do you use more than two pillows to sleep? ..... Yes / No
11. Have you lost or gained more than ten pounds in the past year? ..... Yes / No
12. Do you ever wake up from sleep and feel short of breath? ..... Yes / No
13. Are you on a special diet? ..... Yes / No
14. Do you have or have you had any disease, condition, or problem not listed? ..... Yes / No

FOR WOMEN ONLY: Are you pregnant? Y/N What Month? ____ Are you nursing? Y/N Are you taking birth control pills? Y/N

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient's Signature _____ Date: _____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental records.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payment are not received by the agreed upon dates. I understand that a 1 – 1 ½ % finance charge (18% APR) may be added to my account, in addition to any collections charges.
4. I understand that where appropriate; credit bureau reports may be obtained.
5. I understand that is my responsibility to advise your office of any changes in the information obtained on this form.

Patient's Name _____ Patient's Signature: _____

Parent of Responsible Party _____ Rel. to Patient: _____

FOR OFFICE USE: Reviewed by Dr. _____ Date: _____

Nader Ahdout DDS

Patient Consent Form

Patient's Name _____

In regarding and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.

(Initial)_____

1. **DRUGS, MEDICATIONS, AND ANESTHESIA**: I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of what are, but are not limited to, redness and selling of tissues, vomiting dizziness, miscarriage, and cardiac arrest. I understand that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, not operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty-four (24) hours after my release from surgery). I understand that occasionally, upon injection of a local anesthetic, I may have prolonged persistent anesthesia, numbness, and/or irritation to the area of injection. I understand that if I select to utilize Nitrous Oxide, "Atarax", Chloryl hydrate, "Zanax", or any other sedative, possible risks, include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, and cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway.

(Initial)_____

2. **HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS)**: I understand that the long term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits. PERIODONTICS-I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

(Initial)_____

3. **REMOVAL OF TEETH:** I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissue. The doctor has advised me if this condition persists without treatment of surgery, my present oral condition will probably worsen over time. Potential risks include, but are not limited to, the following: A. Post-operative discomfort, swelling, prolonged bleeding, tooth sensitivity to hot or cold, gum shrinkage (possibly exposing crown margin), tooth looseness, delayed healing (dry-socket)and/or infection(requiring prescriptions or additional treatment, i.e.surgery). B. Injury to adjacent teeth, caps or filings (requiring the recommendation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area. C. Limitation of opening' stiffness of facial and/or neck muscles; change in bite, or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery). D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications. E. Possible bone fracture which may require wiring or surgical treatment. F. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery. G. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth and/or tongue on the operated side, this may persists for several weeks, months, or, in remote instances, permanently. (Initial)_____ I give my consent for the doctor to perform the treatment/procedure/surgery for teeth # _____, or other procedures deemed necessary or advisable as necessary to complete the planned operation. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedure in addition to different from those now contemplated, I request and authorize the doctor to do whatever (s) he may deem advisable. Including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

(Initial)_____

4. **FILLINGS:** I have been advised of the need for fillings, either silver o composite (plastic), to replace tooth structure lost or decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build up, and crowns), which would necessitate a separate charge. I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines. The advantage and disadvantages of alternative materials have been explained to me.

(Initial)_____

5. **ENDODONTIC TREATMENT (ROOT CANAL THERAPY):** The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and his consequences of nontreatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth.

I understand that treatment risks can include, but not limited to the following: A. Post treatment discomfort lasting a few hours to several days to which medication will be prescribed if deemed necessary by the doctor. B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling. Either of which may persist for several days or longer. C. Infection. D. Restricted jaw opening. E. Breakage of root canal instruments during treatment, which may in the judgment of the doctor, be left in the treated root canal or bone as part of the filling material or it may require surgery for removal. F. Perforation of the root canal with instruments, which may require additional surgical treatment o result in premature tooth loss or extraction. G. Risk of temporary or permanent numbness in treatment area. If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or teeth lose. If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

(Initial)_____

6. CROWNS AND BRIDGE (CAPS): I understand that sometimes it is not possible to match the color of the color of the natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy. I understand that like natural teeth, crowns and bridge need to be kept clean, with proper oral hygiene and periodic cleaning, otherwise decay may develop underneath and/or around the margins of the restoration, leading to future dental treatment.

(Initial)_____

7. DENTURES-COMPLETE OR PARTIAL: The problem of wearing denture has been explained to me including looseness, soreness, and possible breakage, and relining due to tissue change. Followup appointments are an integral part of maintenance and success of a prosthetic appliance. The doctor should immediately examine persistent sore spots. I further understand that surgical intervention (i.e. tori [bone] removal, bone recontouring, or implants) may be needed for denture to be probably fitted. I also understand that due to bone or other complicating factors, I may never be able to wear dentures to my satisfactions.

(Initial)_____

8. PEDODONTICS (CHILD DENTISTRY): I understand that the following procedures are to treat pediatric patients and they are acceptable in dental profession.

A. POSITIVE REINFORCEMENT – Rewarding the child who portrays desirable behavior, by use of complements, praise, an apt or hug, and/or token objects or toys.
B. VOICE CONTROL – the attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. HAND – OVER – MOUTH EXERCISE – The disruptive child is told that a hand is to be placed over the child's mouth. When the hand is in place, the dentist speaks directly into the child's ear and tell the child that id the disruptive noise stops the hand will be removed. When the noise stops the hand is removed and the child is praised for cooperating. If the noise resumes the hand again is placed on the mouth and the exercise repeated. At no time is the airway ever restricted.
D. PHYSICAL RESTRAINT – restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special devise (refer to as a "papoose board").
E. NITROUS OXIDE AND/OR ORAL SEDATION - Nitrous Oxide is a mild gas that is mixed with oxygen, and used to sedate a person. It is administrated through a mask placed over the child's nose. Oral sedation is medications administrated to children to help them relax. With their use the parent/or guardian must understand that the child should not eat or drink for a period of four hours prior the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur. I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time. I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction. (Initial)_____

UNDERSTAND THAT NO GURANTEE OR ASSURANCE BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURRATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATION OF THE DOCTOR WHILE I AM UNDER HER/HIS CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS. I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPRATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

_____ _____ Date _____

Patient or Legal representative's signature: Relationship:

_____ _____

Doctor: Witness:

Nader Ahdout DDS

Patient Financial Responsibility:

I agree to be financially responsible for any dental services rendered which are not benefits of my insurance plan or for which my insurance policy does not reimburse Dr. Ahdout. This shall include, but not be limited to, lapses in coverage, cancellation of policy, changes in benefits, and misinterpretation of benefits. If such situations occur Dr. Ahdout's normal and customary fees shall apply. All appointments which are failed or not cancelled 24 hours in advance will incur a $75.00 per ½ hour charge. No further appointments will be made until this charge is paid.

_____ _____ _____

Patient's Name or Guardian's Name: Patient's or Guardian's signature: Date:

Our Policy of Care and Payment:

Ensuring that our patients receive high quality care is the goal of our practice.

Payments are due at the time of treatment. We accept cash and major credit cards. We also have payment plans called Care Credit and LendingClub that allows you to start treatment today and spread payments over time.

Payment Options:

Please indicate below the form of payment you choose to settle your account. Check one:

○ Cash ○ Visa, MasterCard, Amex., Discover ○ Health Loan Credit
(subject to credit approval.)

_____ _____

Patient's signature: **Date:**

Acknowledgement of receipt of notice of privacy practices:

** You may refuse to sign this acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices and Dental Materials Sheet, as required by law.

_____ _____ _____

Patient's Name: Patient's Signature: Date:

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communications barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please Specify). _____

Nader Ahdout DDS

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