WELCOME TO OUR MULTI-SPECIALTY DENTAL GROUP

We value your business and welcome all new referrals from your friends and family. We provide both general and specialty services in house to our patients by qualified doctors.

Our services include:

General Dentistry
Cosmetic Dentistry
Orthodontics (Standard Braces and Invisalign)
Pedodontics (Children's Dentistry)
Hygienist Services
Dental Implants
Oral Surgery (Wisodm Teeth Extraction)
Periodontics (Gum Specialist)
Endodontics (Root Canals Specialist)

Your Doctors:

General

Dr. Poneh Ghasri (General & Cosmetic)
Dr. Sheila Morim(General & Cosmetic)
Dr. Alina Tiraspolskaya (General & Cosmetic)

Specialists

Dr. Bijan Afar D.D.S. (Periodontics)
Dr. Payman Kakoli (Endodontics)
Dr. Monica Sharma (Pediatric Dentistry)
Dr. Jennifer Wu
(Orthodontics Braces & Invisalign)
Dr. Allen Yaghoubzadeh
(*Orthodontics Braces & Invisalign*)

Office Locations:

Wilshire Dental Care
6200 Wilshire Blvd #1508
Los Angeles, Ca 90048
(323)938-6137

Mid-Wilshire Dental Care
6221 Wilshire Blvd # 303
Los Angeles, Ca 90048
(323)931-2000

Westwood
10921 Wilshire Blvd # 904
Westwood, Ca 90024
(310)443-4444

Sunset Plaza Dental
8539 West Sunset Blvd 16
West Hollywood, Ca 90069
(310)855-2434

NoHo Dental Group
11126 Chandler Blvd
North Hollywood, Ca 91601
(818)432-8300

Multi-Specialty Dental Group

Office Location:_____ How did you hear of our office:_____

Patient information

Name:_____ Email:_____

Last First Middle

Address:_____ City:_____ State:_____ Zip:_____

(P.O. box addresses are not acceptable)

DOB:_____ SS#:_____ DL#:_____ State issued:_____

Phone:_____ _____ _____ Sex: M F Marital Status: M S D W

Home Work Cell

Responsible party information

Name:_____ Email:_____

Last First Middle

Address:_____ City:_____ State:_____ Zip:_____

(P.O. box addresses are not acceptable)

DOB:_____ SS#:_____ DL#:_____ State issued:_____

Phone:_____ _____ _____ Sex: M F Marital Status: M S D W

Primary Insurance Information

_____ Relationship to Insured (circle one): Self Spouse Child Other _____

Name of Insured Insured Social Security Number

_____ _____ _____ _____ _____ _____ _____

Employer Employer Phone Address City State Zip Insurance or Employee ID

_____ _____ _____ _____ _____ _____ _____

Insurance Company Address City State Zip Insurance Phone

_____ _____ _____ _____ _____

I hereby authorize assignment of my insurance benefits directly to the provider for services rendered.

Insured Date of Birth I fully understand I am solely responsible for any balance not paid by my insurance company. _____

Intl

Emergency Contact:_____ **Phone:**_____

Relationship to Patient:_____

Dental Information

Have you ever had a bad experience at a dental office **Y N** If so how?_____

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
○	○	Teeth sensitive to cold or heat	○	○	Pain around ear	○	○	Mouth breathing	○	○	Floss once a day	○	○	Do you snore?
○	○	Teeth sensitive to sweets	○	○	Bad breath	○	○	Bleeding gums	○	○	Unpleasant taste	○	○	Smoke
○	○	Food Impacting	○	○	Clenching or grinding	○	○	Swelling or lumps	○	○	Periodontal treatment	○	○	Play sports
○	○	Would like whiter teeth	○	○	Want straighter teeth	○	○	Nervous			Date of last dental exam			

How would you describe your current dental problem?_____

Previous Dentist's Name:_____ Address:_____ Phone:_____

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Do you have any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
AIDS / HIV Positive	○	○	Diabetes	○	○	Hepatitis A	○	○	Rheumatic Fever	○	○	Alzheimer's Disease	○	○
Drug Addiction	○	○	Hepatitis B or C	○	○	Rheumatism	○	○	Anemia	○	○	Easily Winded	○	○
Herpes	○	○	Scarlet Fever	○	○	Angina	○	○	Emphysema	○	○	High Blood Pressure	○	○
Shingles	○	○	Arthritis/ Gout	○	○	Epilepsy or Seizures	○	○	Hives or Rash	○	○	Sickle Cell Disease	○	○
Artificial Heart Valve	○	○	Excessive Bleeding	○	○	Hypoglycemia	○	○	Sinus Trouble	○	○	Artificial Joint	○	○
Excessive Thirst	○	○	Irregular Heart Beat	○	○	Spinal Bifida	○	○	Asthma	○	○	Fainting/ Dizzy spells	○	○
Kidney Problems	○	○	G.I. Disease	○	○	Blood Disease	○	○	Frequent Cough	○	○	Leukemia	○	○
Stroke	○	○	Blood Transfusion	○	○	Frequent Headaches	○	○	Low Blood Pressure	○	○	Thyroid Disease	○	○
Breathing Problems	○	○	Frequent Diarrhea	○	○	Liver Disease	○	○	Swelling of the Limbs	○	○	Bruise Easily	○	○
Genital Herpes	○	○	Lung Disease	○	○	Tonsillitis	○	○	Cancer	○	○	Glaucoma	○	○
Mitral Valve Prolapse	○	○	Tuberculosis	○	○	Chemotherapy	○	○	Hay Fever	○	○	Pain in Jaw Joints	○	○
Tumors or Growths	○	○	Chest Pains	○	○	Heart attack	○	○	Parathyroid Disease	○	○	Ulcers	○	○
Cold Sores	○	○	Heart Murmur	○	○	Psychiatric Care	○	○	Venereal Disease	○	○	Congenital Heart Disorder	○	○
Heart Pace Maker	○	○	Radiation Treatment	○	○	Yellow Jaundice	○	○	Convulsions	○	○	Heart Trouble	○	○
Recent Weight Loss	○	○	Cortisone Medicine	○	○	Hemophilia	○	○	Retinal Dialysis	○	○			

Have you ever had any serious illness not listed above? ○ ○ If yes, please explain: _____

Are you allergic to any of the following? Aspirin / Penicillin / Codeine / Acrylic / Metal / Latex / Local Anesthetics / Any other Allergies ? _____

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 may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now, or have been in the past 2 years? ○ Yes ○ No
If yes, please explain: _____

Name of Physician: _____ Phone Number: _____

Have you been hospitalized or had a major operation in the past 5 years? ○ Yes ○ No
If yes, please explain: _____

Have you ever had a serious head or neck injury? ○ Yes ○ No
If yes, please explain: _____

Are you currently taking any medications, pills or drugs? ○ Yes ○ No
If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No

Are you on a Special Diet? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No

Do you use controlled substance? ○ Yes ○ No

Women: Are you pregnant / trying to get pregnant? ○ Yes ○ No

Women: Taking oral contraceptives? ○ Yes ○ No

Women: Nursing? ○ Yes ○ No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in the condition of my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date: _____ Signature: _____ Reviewed By: _____ Date: _____

Date: _____ Signature: _____ Reviewed By: _____ Date: _____

Date: _____ Signature: _____ Reviewed By: _____ Date: _____

Date: _____ Signature: _____ Reviewed By: _____ Date: _____

Multi-Specialty Dental Group

As a courtesy, we attempt to confirm most appointments 48 hours in advance.
However, if we are unable to reach you, keeping your appointment is your responsibility. Initial:_____

We require an advanced 24 hour notice of cancellation or request to reschedule an appointment.
Initial:_____

Failure to reschedule or cancel your appointment in this time frame will result in a charge of $50 per 1/2 hour appointment(s) for general and $100 per 1/2 hour appointment(s) with specialists. Please note that all Monday appointments shall be canceled by 5 P.M. Friday or a broken appointment charge will be applied.
Initial:_____

As a condition of treatment by this office, financial arrangements must be made in advance. We depend upon timely reimbursement for the costs incurred in rendering care. Financial responsibility on the part of each patient must be determined before treatment.
Initial:_____

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.
Initial:_____

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any insurance payment to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
Initial:_____

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.
Initial:_____

I understand that any fee estimate for dental care can only be extended for a period of six months from the date of the patient examination.
Initial:_____

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of time or condition hereunder shall not constitute a waiver of any other term or condition and I further agree as the responsible party to pay all costs including but not limited to outside collection fees, bank fee, penalties and reasonable attorney fees.
Initial:_____

I grant permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Patient Signature:_____ Date:_____

Patient Print name:_____

HIPPA Consent

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews.

I have been informed that I may review the practices Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, excluding any for information already used or disclosed.

Patient Signature: _____ Date: _____

Patient Print Name: _____

Witness: _____

Multi-Specialty Dental Group

With miracles of modern dentistry, we can restore function, esthetics and comfort to the oral structures, by providing state of the art dental treatment to our patients. Dental treatments are usually successful with excellent outcomes. However, since dentistry is not an exact science, and there are variations in patients' physiological response to dental treatments, in remote occasions complications may occur.

Initials

We are trained and equipped to handle most complications. In case of problems with dental restorations, they will be repaired or replaced for a period of one year without charge to the patient. It is our moral and legal duty to inform our patients of the possibility of complications however unusual and remote they may be.

Initials

Dental Material Fact Sheet:

I have received a copy of the Dental Material Fact Sheet, Prepared by the California Dental Board and provided to me by this office

Initials

Language:

In reading and signing this form, it is understood that ENGLISH is the language that I understand and use to communicate. Otherwise, this document has been translated to me and I fully understand its content.

Initials

Change in Treatment Plan:

I understand that due to changing conditions, it may be necessary to change or add procedures, due to new findings not present during the initial examination and treatment planning or changes in the priorities of the treatment sequences. I understand that I will be informed of these changes before the initiation of the clinical procedures

Initials

Radiographs (X-rays):

I have been advised, and I consent to the following:

a. I am to receive a full mouth series of X-RAYS every five years or when in the judgment of the doctor, it is necessary. This series of radiographs will provide diagnostic information and documentation for my teeth and surrounding oral tissues.
b. I will receive periodic examination and X-rays for the correct and accurate diagnosis of my oral condition.
c. I will consent to diagnostic X-rays at a frequency as assessed by the doctor.
   I understand that all reasonable precautions will be taken to minimize my exposure to unnecessary radiation.

Initials

I have read the above statements and have received a copy of them if requested, and recognize their importance in helping me make decisions. My initials indicate that I have read and understand this consent document. I recognize that failures can occur for all kinds of reasons and that complications can occur in any procedure. I also understand that, where decay has occurred, or a tooth has fractured or abscessed, that these same forces are still working on the tooth even after it has been restored: therefore, decay or fracture can still occur as the restored tooth is no better than what nature has given in the first place. If for any reason a conflict or disagreement should arise I will first present such conflict or disagreement to my attending dentist in order to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation / mediation board such as the dental society and agree to accept their resolution in lieu of pursuing remedies by way of litigation. I also understand that this agreement is binding on my heirs and all other family members. I now give my consent to the attending dentist to render to me the dental treatment that we have agreed is necessary (I also agree to reimburse the attending dentist for all services rendered to me and I am aware that the payment for these services is due at the time they are rendered.

Patient Print Name Date Patient Signature

Print SUBMIT RESET