A) Patient Information: Chart No:_____

Patient name:_____DOB:_____Age_____
Address:_____Apartment No_____
City:_____State_____Zip code _____Tel: ( )_____
Email:_____
Driver License No or California Id:_____SSN:_____-_____-_____
Occupation: _____Employer:_____
Time employed:_____Tel: ( )_____Ext:_____
Address:_____
City _____State:_____Zip code:_____

B) Responsible Party Member

Name:_____Relationship:_____
DOB:_____SSN:_____Driver License:_____
Address:_____Apt No:_____Tel No :( )_____
City:_____State_____Zip code: _____

Occupation _____Employer_____
Time Employed _____Tel :( )_____Ext_____
Address _____
City _____State: _____Zip code_____

Dental Insurance Information

Name of Insurance :_____Telephone :( )_____
Subscriber_____Relation to Patient:_____
Subscriber DOB:_____Subscriber SSN_____

Authorization to use and collect benefits to the Insurer

I authorize Dr. Alireza Movassaghi or his assigned of Alondra Dental Associates to obtain the necessary information and benefits of my dental insurance for its use, in The dental office, and for the payment for the professional dental services received. With my signature at the bottom of this form, I accept that I understand, and I Admit the responsibility Total financial of my dental treatment in case my Insurer, for any reason, does not cover the cost of any treatment provided

C) In Case of an Emergency

In case of an emergency please call: _____
Phone: ( )_____Relation to patient:_____

How did you hear about the office? _____

Patient Signature (if minor signature of parent) _____Date:_____

PATIENT CONSENT FORM

Patient's Name **Chart #**

I understand that I need the following dental treatment: Fillings[ ], Bridges[ ], Crown[ ], Dental Extractions[ ], Impacted Teeth Extractions[ ], Root Canal[ ], Full Denture[ ], Periodontics [ ], Posts [ ], Sealants [ ], X-Rays[X], Other [ ],_____.

Initials _____

1. MEDICATIONS AND DRUGS. I understand that antibiotics and other medications can cause allergic reactions as redness and swelling of tissues, rash, pain, vomiting, diarrhea and/or anaphylactic shock (Severe Allergic Reaction). **Initials** _____

2. CHANGES IN DIAGNOSIS AND/OR TREATMENT PLAN. I understand that during treatment it may be necessary to change some of the procedures, because of conditions found while working on the teeth, and were not discovered or noted during the initial examination for whatever reason. I give my permission to the Dentist to make those changes as necessary. **Initials** _____

3. ANESTHESIA. I realize the risk involved in receiving a local anesthetic, some of which are: partial facial paralysis, inflamed tissue, adverse reaction to drugs causing cardiac arrest, miscarriage, hemorrhage, temporary and/or permanent nerve damage and or numbness.

Initials _____

4. FILLINGS. To restore cavities, silver fillings are placed on back teeth (molar), and white filling for front teeth. Sometimes white fillings are place on back teeth, if the Dentist recommends. When the cavity is very close to the nerve, the teeth may be sensitive to cold, hot and air for a few weeks; if this happens, it is recommended to eat and drink things at room temperature for a few weeks. In some cases a base of medication is placed prior or under the filling to eliminate sensitivity, but this does not guarantee that the nerve won't be affected; in such situation a different treatment will be recommended. **Initials** _____

5. REMOVAL OF TEETH. I authorize the dentist to remove the following teeth:_____ and any other necessary under paragraph #2. I understand that removing the teeth does not always remove all the infection if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are hemorrhage, pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia), that can last for an indefinite period of time; fracture of adjacent teeth, fracture of bone jaw. I understand I may need further treatment by specialist or even hospitalization if complications arise during or following treatment**.** **Initials** _____

6. CROWN AND BRIDGES. I understand that sometimes it is possible to match the natural shade of my teeth exactly with artificial teeth. I also understand that I will be wearing temporary crowns while the final work is completed , and which may come off easily, and that I must be careful to ensure that they are kept on until the permanent crown/bridge are delivered. I also promise to come back on my scheduled appointment to have my permanent crown/bridge cemented, due to serious tissue damage or loss of the tooth/teeth involved, and that if I delay placement I may cause the involved teeth to move and the permanent crown/bridge no longer fit properly. **Initials** _____

7. FULL AND PARTIAL DENTURES. I realize that full or partial dentures are artificial, constructed of hard or flexible acrylics, metal and porcelain. The problems of wearing these appliances have been explained to me, including looseness of the abutment teeth, soreness and redness of tissue and bone, and pain among others. I understand that several adjustments will be necessary as I get comfortable wearing them, and that they can fracture, bend and even brake with daily use. Also, I was told of the eventual need of reline in the future due to the constant change of my tissue and bone shape. **Initials** _____

8. SUBGINGIVAL ROOT PLANING AND GUM TREATMENT (Deep Cleaning). I understand and it was explained to me, that due to the accumulation of dental tartar, I have Periodontal Disease, a serious incurable condition, but controllable if properly treated. This conditions affects my gums, teeth and surrounding bone causing bleeding, bad breath and bad taste in my mouth, and if left untreated, it can lead to the lose of my teeth. It's been recommended to consult a specialist (Periodontics) to re-evaluate this condition with the possible need of specialize treatment, after my deep cleaning. **Initials** _____

9. ROOT CANAL THERAPY. By choosing this treatment, there is no guarantee that a root canal therapy will save my tooth completely. There are certain unexpected complications that may occur immediately or after undefined period of time, such as acute and chronic infection, pain that could be temporary or constant, swelling, and root or tooth fracturing, that may require surgery, alternative treatments, or in some cases tooth extraction are recommended for the patient's well-being. Sometimes during treatment, if the Dentist sees that the case is very difficult, he will refer the patient to the specialist (Endodontist) for completion of treatment. In some cases, the roots of the tooth are very narrow or curved, that some of the instrument might separate inside the root; broken instrument may or may not be removed; the Dentist will inform and explain to you the risks and options if this occurs; it will be the patient's decision to complete the treatment. **Initials** _____

Hereby with my signature, I request and authorize Alondra Dental Associates and Professional Staff, to only perform the requested treatment. I had the opportunity to ask any questions regarding the diagnosis and all recommended dental procedure; extra information and models were shown to me for better understanding of the final results. I understand that any and all resulting extra costs for unexpected treatment plan changes and/or complications during and/or after the treatment, are of my fully responsibility. I know that the practice of Dentistry and surgery, is not exact science, and therefore Alondra Dental Associates can't guarantee the final result under any circumstances.

Patient or Responsible Party Signature **Date**

Dentist's Signature **Date**

HEALTH HISTORY

ENGLISH

I. CHECK APPROPRIATE ANSWERS (leave blank if you don'tunderstand and the question):

YES NO

1. Is your general health good?
2. Has there been a change in your health within the last year?
3. Have you been hospitalized or had a serious illness in the last three?
   Please Explain_____
4. Are you being treated by a physician now?
   Please explain_____
   Date of last exam ___/_____/_____date of last dental apt_____/_____/_____
5. if yes to 4 above, name of medical doctor _____
   Phone number (____)_____.
6. Have you had problems with prior dental treatment?
   Please explain _____
7. Are you allergic to any medications?

II. HAVE YOU EXPIRIENCED

8. Chest pain (angina)?
9. Swollen anides?
10. Shortness of breath?
11. Recent weight loss, fever, night sweats?
12. Persistent cough coughing up blood?
13. Bleeding problems bruising easily?
14. Sinus problems?
15. Difficult swallowing?
16. Diarrhea, constipation, blood stools?
17. Frequent vomiting, nausea?
18. Difficult urinating, blood in urine?
19. Dizziness?
20. Ringing in ears?
21. Headaches?
22. Fainting spells?
23. Blurred visions?
24. Seizures?
25. Excessive Thirst?
26. Frequent urination?
27. Dry mouth?
28. Jaundice?
29. Joint pain, stiffness

III. DO YOU HAVE OR HAD YOU HAD:

30. Heart disease?
31. Heart attack, heart disease?
32. Heart murmurs?
33. Rheumatic fever?
34. Stroke, hardening of arteries?
35. High blood pressure, cholesterol?
36. TB, Emphysema, other lung disease?
37. Hepatitis, other liver disease?
38. Allergies to Latex?
39. Allergies to: drugs, food, medications?
40. Allergies to: Drugs, food, mediations?
41. AIDS or ARC?
42. Tumors, caner?
43. Arthritis, rheumatism?
44. Eye disease?
45. Skin disease?
46. Anemia?
47. VD (syphilis or Gonorrhea)?
48. Herpes?
49. Kidney bladder Disease?
50. Thyroid, adrenal disease?
51. Diabetes adrenal disease?

IV. DOI YOU HAVE OR HAVE YOU HAD:

52. Psychiatric Care?
53. Radiation Treatment?
54. Chemotherapy
55 Prosthetic Heart Valve?
56. Artificial Joint?
57. Hospitalization?
58. Blood Transfusion?
59. Surgeries?
60. Peacemaker?
61. Contact Lenses

YES NO

62. Recreational drugs?
63. Drug, medicines (including Aspirin)
    Please list_____
64. Tobacco in any form?
65. Alcohol?

V I SOLO PARA MUJERES

66. Are you or could you be pregnant or nursing?
67. Taking birth control pills

VII ALL PATIENT

68. Have you ever had Phen Phen/Redux to lose weight?
69. Do you have/had any other disease or medical problem NOT listed on this Form?
    Please explain_____

To the best of my knowledge, I have answered every question completely and accurately, I will inform my dentist of a change in my health and / or medication.

Patients' Signature_____Date_____Dentist Signature_____Date_____.

If minor, Signature of Parent or Guardian_____Date _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Alondra Dental Associates ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Alondra Dental Associates Privacy Official at:

8800 Alondra Blvd Suite A

Bellflower, CA 90706

(562)317-4917 Phone

(562)232-3145 Fax

info@torrancedentalassociates.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on March 13, 2014.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military

(domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. You're Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance

of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is March 13, 2014.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received, Alireza Movassaghi, Notice of Privacy Practices.

Patient's Name

Patient or Responsible Party Signature **Date**

Please notify your dentist if you have you taken or are currently taking any medications listed below:

	Yes	No
Actonel (Risedronate)		
Aredia (Pamidronate)		
Boniva (Ibandronate)		
Didronel (Etidronate)		
Fosamax (Alendronate)		
Skelide (Tiludronate)		
Zometa (Zoledronic Acid)		

Signature of Patient / Responsible Party Date

Favor de notificar a su Dentista si usted ha tomado o esta tomando cualquiera de los medicamentos mencionados arriba.

Nombre Del Paciente/Tutores Fecha