LONG BEACH DENTAL STUDIO
Cosmetic & General Dentistry

We are pleased to welcome you to Long Beach Dental Studio. Please take a few minutes to fill out this form. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health and beautiful smile.

Patient Information

Name: Last _____ First _____ MI _____ Soc.Sec.# _____

Address _____ City _____ State ____ Zip _____

Sex: F M Age: _____ DOB: _____ Cell Ph: _____ Home Ph: _____

Email: _____ Whom may we thank for referring you? _____

Occupation: _____ Employer: _____

In Case Of Emergency Contact _____ Relationship _____ Phone # _____

Dental Insurance

Person Responsible for Account _____ DOB: _____ Subscriber's Address _____

Relationship to Patient: _____ Insurance Co. _____

Group # _____ Subscriber # _____ Phone # _____

Is the patient covered by additional Insurance ? Yes No Insurance Co. _____

Subscriber's Name: _____ Relationship to Patient: _____

DOB: _____ SS# _____

Group # _____ Subscriber # _____ Phone# _____

Dental History

Reason for today's visit _____ Last Visit _____

Bleeding gums	**Y N**	**Clicking/Popping jaw**	**Y N**	**Dry Mouth**	**Y N**	**Jaw pain**	**Y N**
Broken fillings	**Y N**	**Pain around ears**	**Y N**	**Braces**	**Y N**	**Sores in mouth/lips**	**Y N**
Periodontal Treatment	**Y N**	**Sensitivity to hot, cold, sweets, biting (circle all that apply)**					

How often do you brush your teeth? _____ Floss? _____

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

What would you like to change? _____

Medical History

Physician's name: _____ Phone # _____

Date of last visit _____ Have you had serious illness or operation? Y N If yes, describe _____

Are you currently under physician care ? Y N If yes, describe _____

AIDS/HIV	Y N	Anemia	Y N	Arthritis	Y N	Artificial joints	Y N	Asthma	Y N
Abnormal bleeding	Y N	Blood Disease	Y N	Diabetes	Y N	Cancer/Chemo/Rad	Y N	Stroke	Y N
Chemical dependency	Y N	Smoking/Vaping	Y N	Emphysema	Y N	Fainting/dizziness	Y N	Sinus Trouble	Y N
Headaches(Currently)	Y N	Heart murmur	Y N	Heart problems	Y N	Pacemaker	Y N	Kidney Disease	Y N
Hepatitis A, B, C	Y N	Herpes/cold sores	Y N	Low Blood Pressure	Y N	High Blood Pressure	Y N	Tuberculosis	Y N
Liver Disease	Y N	Psychiatric Care	Y N	Rheumatic Fever	Y N	Thyroid Problems	Y N	Marijuana use	Y N
Fen-Phen Drugs	Y N	Osteoporosis	Y N	Venereal Disease	Y N	Epilepsy	Y N		

Do you have any disease, condition or problems not listed above that you think I should know about ? Y N

Please explain: _____

Women ONLY: Are you pregnant ? Y N Nursing? Y N

Medications:

_____

_____

Allergies:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Future visit medical updates

Have there been any changes in your health since your last dental appointment? Y N

Describe?_____ Medications?_____
Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

Have there been any changes in your health since your last dental appointment? Y N

Describe?_____ Medications?_____
Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

Have there been any changes in your health since your last dental appointment? Y N

Describe?_____ Medications?_____
Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name _____ **Address** _____

To The Patient-Please Read The Following Statement Carefully

***PURPOSE OF CONSENT*: By signing this form, you will consent to *Long Beach Dental Studio* and *Dr. Jasmine Minasyan* use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.**

***NOTICE OF PRIVACY PRACTICE*: Upon request, you have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.**

You may obtain a copy of our Notice of Privacy Practices, Including any revisions of our Notice, at any time by contacting Long Beach Dental Studio at (562)436-2950.

***RIGHT TO REVOKE*: You will have the right to revoke the Consent at any time by giving us written notice. Please understand the revocation of the Consent will not affect any action we took reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.**

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ **Date** _____

If the Consent is being signed by a personal representative on behalf of the patient please complete the following:

Personal Representative's Name _____

Relationship to Patient _____

YOU ARE ENTITELED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT:

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature _____ **Date**_____

INFORMATIONAL PURPOSES ONLY

GENERAL DENTISTRY INFORMED CONSENT

Dentist: Minasyan D.D.S. / Dental Studio Patient: X _____

1. **WORK TO BE DONE:** I understand that I am having the following work done: Fillings ( ), Bridges ( ), Crowns ( ), X-rays ( ) Extractions ( ), Impacted teeth removed ( ), Root Canals ( ), Dentures ( ), Other _____. (Initials X _____)
2. **DRUGS AND MEDICATION:** I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. (Initials _____)
3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. (Initials _____)
4. **REMOVAL OF TEETH:** Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) And I authorize the dentist to remove the following teeth: _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are 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 or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility. (Initials _____)
5. **CROWNS, BRIDGES, AND CAPS:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my news crown bridge, or cap (including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying permanent cementation. (Initials _____)
6. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it. (Initials _____)
7. **PERIODONTAL LOSS (TISSUE AND BONE):** I understand that I have a serious condition, causing gum and bone inflamation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition. (Initials _____)
8. **FILLINGS:** I understand that care must be exercising in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. (Initials _____)
9. **DENTURES:** I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are some common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of 30 days, there will be additional charges. (Initials _____)

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of the dental fees. I agree to pay any attorney's fees, or court costs, that may be incurred to satisfy this obligation.

Signature of Patient X _____ Date: X _____

Signature of Dentist _____ Date: _____