



Save 20 minutes of time filling out paperwork at our office by **FAXING** your filled out paperwork to us at **(858) 755-8996** or emailing it to **luiza@safariandmd.com** prior to your appointment. This will allow us to process you into our system before your visitation and prepare us to take care of you in the best way possible! For more information, please visit our website at **www.safariandmd.com**

Welcome!

We are delighted that you have chosen our office to care for your dental needs. You have probably noticed that we are different from the average dental practice. When you visit our office you will find a unique, friendly, and relaxing environment. All of our treatment is designed to be painless, high quality, and to exceed all of your expectations. We use the most recent technology and techniques our industry has to offer. It is for these reasons that we always tag our dental practice as Exceptional Dentistry. Our greatest strength lies not in what you see, but in how you are treated. The services we can offer to you include:

- ❖ **COSMETIC DENTISTRY:** including tooth colored fillings, ZOOM tooth whitening, porcelain veneers & crowns, and EXTREME MAKEOVERS. We use the best materials and techniques available to get the best result.
- ❖ **IMPLANT DENTISTRY:** To help replace any missing teeth or stabilize loose dentures. Dental implants are becoming the new alternative option in tooth replacement.
- ❖ **TMJ TREATMENT:** Extensive training and technology is used to help you get rid of headaches, shoulder and neck pain, dizziness (Vertigo), pain and tenderness around the jaw and ear, sensitive teeth, worn down or broken teeth, sinus problems and snoring.
- ❖ **SLEEP APNEA TREATMENT:** Do you have Sleep Apnea? Do you snore? Does your partner complain that he or she cannot sleep? Ask us how we can help the both of you.
- ❖ **ORTHODONTICS for Adults and Children:** We can provide our patients with several options including; Invisalign, clear/tooth color brackets, metal brackets, and traditional braces. These options can be designed for each patient's individual needs in order to achieve optimum results.
- ❖ **GENERAL DENTISTRY:** these are the services a patient would expect to see in an average dental office such as; cleanings, fillings, crowns, root canal treatment, and extractions. We excel in this area and have a bias to providing **comfortable and predictable** services.
- ❖ **FULL MOUTH REHABILITATION:** There is nothing more rewarding than being able to function normally and also to look 15-20 years younger.

By filling out the enclosed questionnaire, we can find out what areas you are interested in. Ultimately, whatever treatment you receive is completely your choice. During the examination phase, we are here to show you what options are available.

And always remember: if you have **any questions** or **concerns** at all, please don't hesitate to bring it to our attention. We are here to take care of you.

Sincerely,

Shahin Safarian, DMD, MBA, LVIF

Dear Friend,

We understand that the first appointment to our office is very important for you. You may even be worried about finding the office on the day of your appointment. With that in mind, we have enclosed detailed directions to our practice.

We welcome you to our family of guests!

The Team at Dr. Safarian's Office

Directions to our office:

Irresistible Smiles
Dr. Shahin Safarian
4765 Carmel Mountain Rd, Suite 203
San Diego, CA 92130
Phone (858) 755-8993

❖ **Heading from the 15**

Take 56 west and exit El Camino Real. Turn left (heading south). The road will wind and turn into Carmel Mountain Rd. Continue TO East Ocean Air Drive. Turn right into Torrey Hills Plaza. Our office is located in the Medical and Dental building on your left as you enter the parking lot. You can park in the carport attached to the medical building.

❖ **Heading 5 North**

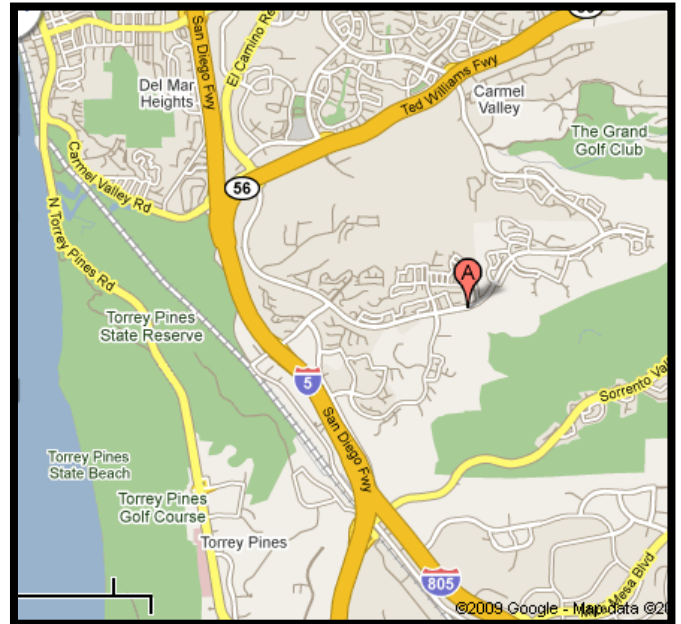
Take exit for the 56 local bypass and exit at Carmel Mountain Rd. Turn right at the end of ramp. Turn right on the second light (Carmel Mtn. Rd) and continue until you see Wells Fargo on your right. Turn right into Torrey Hills Plaza. Our office is located in the Medical and Dental building on your left as you enter the parking lot. You can park in the carport attached to the medical building.

❖ **Heading 5 South**

Exit at Carmel Mountain Rd. Turn left at end of ramp. Turn right at Carmel Mountain Rd (the road turns into El Camino Real if you turn left). Continue until you see Wells Fargo on your right. Turn right into Torrey Hills Plaza. Our office is located in the Medical and Dental building on your left as you enter the parking lot. You can park in the carport attached to the medical building.

❖ **Heading 805 North**

Take exit for the 56 Bypass and then exit at Carmel Mountain Rd. Turn right at the end of ramp. Turn right on the second light (Carmel Mtn. Rd) and continue until you pass East Ocean Air Drive where you see Wells Fargo and VONS on your right. Turn right into Torrey Hills Plaza. Our office is located in the Medical and Dental building on your left as you enter the parking lot. You can park in the carport attached to the medical building.





Irresistible Smiles
CHANGING LIVES DAILY

Personal Information

Mr. Mrs. Miss _____ Birthdate _____

Home Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Number _____

Email Address _____

Person Financially Responsible _____ Relationship _____

****We confirm appointments by sending text messages and emails 1 week and 1 day before your scheduled appointment. Please indicate which of these methods (at least one) we may utilize: Text Message Email**

How did you hear about us?

- | | |
|--|---|
| <input type="checkbox"/> Family member, friend or associate
_____ | <input type="checkbox"/> Google/Bing/Yahoo or other search engine |
| <input type="checkbox"/> Insurance Co: _____ | <input type="checkbox"/> Groupon <input type="checkbox"/> Living Social <input type="checkbox"/> Buy With Me <input type="checkbox"/> Local Twist |
| <input type="checkbox"/> Doctor _____ | <input type="checkbox"/> Other Internet Source: _____ |
| | <input type="checkbox"/> Other: _____ |

We strive to fulfill your individual dental needs. Please help us learn more about you by answering all of the following questions. Thank you!

When was your last dental visit? _____ Last Dental Cleaning? _____

Are you having any areas of concern? _____

How do you feel about the appearance of your face and smile? _____

In your opinion, what do you think is the present state of health of your mouth? _____

What do you know about our office and what expectations do you have? _____

How healthy do you want us to get your mouth?

- Don't really care
- Average
- Ideal / best possible

What quality of dentistry do you want us to recommend?

- Just Patch it
- Average
- Ideal / best possible

Has fear ever been an issue for you in a dental office?

- Yes No

Is time a factor in getting your dental work done?

- Yes No

Is the cost of dental treatment a concern for you?

- Yes No

Should you need treatment, at what point would you like us to address it?

- When my tooth hurts or breaks
- When something is worsening
- When something isn't ideal

Which of the following dental perspectives are you interested in?

- | | | |
|--|---|--|
| <input type="checkbox"/> TMJ Treatment | <input type="checkbox"/> Cosmetic Dentistry | <input type="checkbox"/> Sleep / Snoring Treatment |
| <input type="checkbox"/> Full Mouth Rehabilitation | <input type="checkbox"/> Orthodontics | |
| <input type="checkbox"/> Implant Dentistry | <input type="checkbox"/> General Dentistry | |

Is there any additional information that you would like to let us know?

Health and Dental History

Emergency Contact Person _____ Relationship _____

Emergency Contact Phone # _____ Alternate Phone # _____

MEDICATION: Are you currently taking any medication, including regular doses of aspirin?

No Yes, Please list: _____

ALLERGIES: Are you aware of having an allergic reaction to any medication or substance? (Including latex and anesthetics)

No Yes, Please list: _____

MEDICAL CARE: Have you been under the care of a medical doctor during the past two years?

No Yes, Please explain: _____

Indicate which of the following medical conditions you have had, or have at present.

Heart Concerns	Yes	No	Stroke	Yes	No	Kidney Trouble	Yes	No
Congenital Heart Disease	Yes	No	Epilepsy/ Seizures	Yes	No	Bell's Palsy	Yes	No
Heart Murmur	Yes	No	AIDS/HIV	Yes	No	Diet Drugs (such as Phen-Fen)	Yes	No
Mitral Valve Prolapse	Yes	No	Psychiatric/ Psychological	Yes	No	Diabetes	Yes	No
Artificial Heart Valve	Yes	No	Latex Sensitivity	Yes	No	Hepatitis	Yes	No
Pacemaker	Yes	No	Liver disease/ Jaundice	Yes	No	Neurological Disorders	Yes	No
High Blood Pressure	Yes	No	Artificial Joints	Yes	No	Radiation/ Chemotherapy	Yes	No

If you have or have had any disease, condition, or problem not listed above, please specify below:

If applicable, please provide additional explanation for any conditions you have indicated.

Do you smoke or chew tobacco? No Yes, For how long? _____


Have you ever had any cosmetic procedure? No Yes, What procedure? _____

Does floss shred when you use it? No Yes Does food pack or catch between your teeth? No Yes

Do your gums bleed? No Yes Does your breath concern you? No Yes

WOMEN: Are you pregnant? Yes No Are you nursing? Yes No Are you taking birth control? Yes No

I understand the above information in necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.



Patient Signature _____ Date _____

Please complete all of the following questions. We understand that you may not be seeking TMJ and/or Sleep Treatments. We appreciate your cooperation. Thank you!

TMJ History & Symptoms Please indicate which of the following symptoms you have had in the past or currently have.

Headaches	Yes	No	Tender, Sensitive Teeth	Yes	No	Tinnitus (Ringing in the ears)	Yes	No
Migraines	Yes	No	Difficulty Chewing	Yes	No	Paresthesia of fingertips (tingling)	Yes	No
Facial Pain	Yes	No	Cervical Pain	Yes	No	Thermal Sensitivity (hot and cold)	Yes	No
Loose Teeth	Yes	No	Dysphasia (Difficulty swallowing)	Yes	No	Nervousness / Anxiety/ Insomnia	Yes	No
Jaw Pain	Yes	No	Clenching / Bruxing	Yes	No	Trigeminal Neuralgia	Yes	No
Jaw Noise or Popping	Yes	No	Postural Problems	Yes	No	Ear Congestion	Yes	No
Limited Jaw Opening	Yes	No	Vertigo (Dizziness)	Yes	No	Other _____	Yes	

Additional Information: Please provide additional information you would like us to know regarding your TMJ history.

Sleep, Snoring and Apnea History

Do you become easily fatigued?	Yes	No	Do you wake up with a headache?	Yes	No
Do you have problems with insomnia?	Yes	No	Do you often fall asleep reading or watching television?	Yes	No
Do you sleep well?	Yes	No	Have you fallen asleep during the day against your will?	Yes	No
Do you dream?	Yes	No	Have you been more irritable and short tempered?	Yes	No
Do you have trouble falling asleep or staying awake?	Yes	No	Have you pulled off the road while driving due to sleepiness?	Yes	No
Do you snore or have been told you do?	Yes	No	Have you felt that your memory or intellect is impaired?	Yes	No
Have you been told that you stop breathing while you sleep?	Yes	No	Have you had chronic sleepiness, fatigue or weariness that you cannot explain?	Yes	No
Do you have difficulty breathing through your nose?	Yes	No	Do you have any immediate family members diagnosed/treated with sleep disorder?	Yes	No

Sleep Patterns: How many hours on average do you sleep per night? _____

What % of the time that you are in bed are you asleep? _____ How many times/night do you wake up? _____

How would you rate the quality of your sleep? (1 = very poor, 10 = excellent) 1 2 3 4 5 6 7 8 9 10

Sleep Treatment History: *If you have had prior TMJ/Sleep Apnea treatment, please fill out the following:


Which sleep disorder have you previously been treated for? _____

Treating doctor (Name and Location) _____

When were you treated? _____ Was treatment effective? _____

Sleep Center Name & City _____ Date of Study _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient Signature  _____ Date _____

GENERAL DENTISTRY INFORMED CONSENT

Patient Name: _____

❖ *We understand that your initial visitation to our practice may not involve an examination, x-rays or prescription medications. We ask that you initial below to understand our policies and for future appointments that may involve these common procedures/treatments. We appreciate your cooperation.*

INITIALS

GENERAL CONSENT

I consent to the following treatment to be done periodically:

Exams X X-rays X Prophy (Cleaning) X Fluoride X Consultations X

INITIALS

DRUGS AND MEDICATION

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling tissues, pain, itching, vomiting, and/or anaphylactic shock.

INITIALS

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 examinations. For example, root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

INITIALS

FINANCIAL RESPONSIBILITY

As a courtesy to you, we will file and submit all insurance claims on your behalf. We request that you pay your estimated co-payment at the time of service. Please note that estimated insurance benefits are subject to actual payment by your insurance carrier and are NOT a guarantee of payment by your insurance plan. You are ultimately responsible for all fees associated with treatment. A service charge of 1.5% is applied on accounts past due 30 or more days.

INITIALS

CANCELLATION POLICY

If you are ever unable to make an appointment you have scheduled with us, please notify us at least 48 hours in advance. We would be glad to reschedule the appointment at a more convenient time for you. However, when an appointment is missed and/ or cancelled without a **48 HOUR NOTICE**, we reserve the right to charge you a **\$50.00 FEE** for each scheduled hour.

INITIALS

Photographic Release and Consent: I consent and authorize Irresistible Smiles to use my first name and/or photograph(s), video(s) and/or any other multimedia format as may be necessary for advertising, trade, or any other lawful purpose and I release and forever discharge Irresistible Smiles from any claim, demands, or liability on account of such use for any reason.

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 understand that no other Dentist is responsible for my dental treatment.

I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed 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 dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation, as well as attorney's fees and costs incurred by the dentist if I unsuccessfully assert a claim against any dentists for treatment I received in this office.

Signature of Patient: _____ Date _____

Signature of Doctor: _____ Date _____



Insurance Information Form

- ❖ *In order to process your insurance claims, we ask that you fill out this form in its entirety. Missing information may result in claims being denied by your insurance carrier which in turn will create a balance in our system for which the patient is responsible.*
- ❖ *We do NOT require this page for consultations, ZOOM whitening treatment or elective care procedures. However, you are responsible for providing this information prior to any procedures for which you would like us to submit a claim.*

Dental Insurance Company _____
 Insurance Company Phone Number _____
 Member ID Number _____
 Group Name / Employer _____
 Group Number _____

* **Employer** = Name of employer through which you are insured, ex. City of SD. If plan has been purchased individually, please state "Self"

Policy Holder Information: (This is the main person on the plan, ex. Spouse or Parent)

Name _____
 Date of Birth _____
 Social Security Number _____

Relationship to Patient:

Patient Information: (Please fill out this portion if the patient is not the policy holder)

Name _____
 Date of Birth _____
 Social Security Number _____

* **Social Security** - When submitting insurance claims, the clearinghouse will reject any claims without a SS#. While we require that you provide a SS# for claims submission, we do not share your SS# with anyone for any other reason.

X _____
Patient or Guardian signature

Date



HIPAA CALIFORNIA NOTICE FORM

This notice describes how medical and dental information about you may be used and disclosed, and how you can have access to this information.

1. Disclosures for treatment, payment, and healthcare operation:

We may use or disclose your protected health information (PHI), for certain treatment, payment, and healthcare operation purposes without your authorization, In certain circumstances we can do so when the person or business requesting you PHI gives us a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment and Payment Operations”
- “Treatment” is when we or another healthcare provider diagnose or treat you. An example of treatment would be when we consult with another health care provider such as your physician or another dentist, regarding your treatment.
- “Payment” is when we obtain reimbursement for our service. An example of payment is when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine your eligibility or coverage.
- “Health Care Operation” is when we disclose you PHI to your health care service plan, (for example, your health insurer), or your other health care providers, contracting with your plan, for administering the plan, such as management and care coordination.
- “Use” applies only to activities within our office, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- “Disclosure” applies to activities outside out office, such as releasing, transferring, or providing access to information about you to other parties.
- “Authorization” means written permission for specific use or disclosure.

2. Use and Disclosures Requiring Authorization:

We may use your PHI for purposes outside treatment, payment, and health care operation, when your appropriate authorization is obtained. In those instances, when we are asked for information for purposes outside treatment, payment, and health care operation, we will request your authorization prior to forwarding your PHI to them.

3. Health Oversight:

If a complaint is filed against us with the California Dental Board, the Board has the authority to subpoena your PHI and dental record relevant to the complaint.

4. Judicial or Administrative Proceedings:

If you are involved in a court proceeding and a request is made about the professional services that we have provided to you, we will not release your information without:

- a. Your written authorization or authorization of your attorney or personal representative.
- b. Court order.
- c. A subpoena duces tecum (a subpoena to produce records). When a party seeking records provides our office with a showing that you or your attorney have been served a copy of the subpoena, affidavit and the appropriate notice, and you have not notified us that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or when the evaluation is court ordered. We will inform you in advance if this is the case.

5. Workers Compensation:

If you file a workers’ compensation claim, we must furnish a report to your employer, incorporating our findings about your injury and treatment, within five days from the date of your initial examination, and at subsequent intervals as may be required by the administrative director of the Workers Compensation Commission, in order to determine your eligibility for workers compensation.

I hereby authorize the use or disclosure of my protected health information as described below. I understand and acknowledge the following:

- I am authorizing my protected health information to be used or disclosed as permitted by Federal Privacy Regulation.
- I may inspect or receive a copy of my personal health information.
- My Doctor will not condition my treatment or payment for my treatment on obtaining this authorization form me.
- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to my doctor. My revocation will not affect any prior action taken by my doctor on reliance on my authorization.

Patient/Guardian Signature _____ Date _____