IRRESISTIBLE SMILES
COSMETIC AND FAMILY DENTISTRY
SHAHIN SAFARIAN DMD, MBA

Save 15 minutes of time filling out paperwork at our office by **FAXING or EMAILING** your filled out paperwork to us prior to your appointment time. This allows us to verify insurance before your appt.

Please arrive **15 min** prior to the start of your appt if you do not have your forms completed ahead of time.

Torrey Hills Appts: mayya@safariandmd.com or Fax 858-755-8996
Chula Vista Appts: emily@safariandmd.com or Fax 619-656-6789

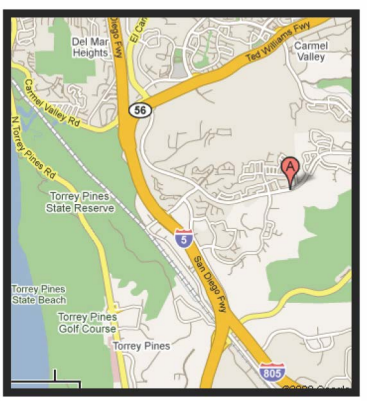
Welcome!

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:** white fillings, ZOOM teeth whitening, Porcelain Veneers & Crowns, Recontouring and Bonding.
- **IMPLANT DENTISTRY:** Implants are the newest option in tooth replacement for bridges, missing teeth or dentures.
- **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 someone in your family suffer from a sleep disorder? Does your partner complain that he or she cannot sleep? Ask us how we can help the both of you.
- **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.
- **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.
- **FULL MOUTH REHABILITATION:** There is nothing more rewarding than being able to function normally and also to look up to 20 years younger.

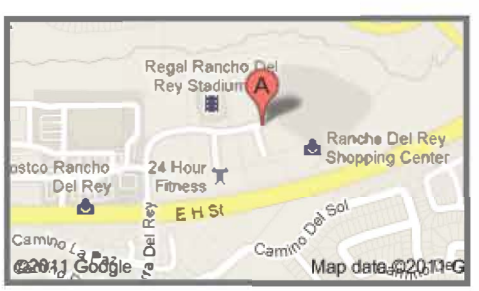
By filling out the enclosed questionnaire, we can find out what areas you are interested in. Ultimately, whatever treatment you receive is completely your choice. During the examination phase, we are here to show you what options are available. And always remember: if you have **any questions** or **concerns** 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**



Directions to TORREY HILLS:
4765 Carmel Mountain Rd, Suite 203, San Diego, CA 92130 Phone (858) 755-8993

❖ **Heading from the 15:** 56W, exit El Camino Real, turn LEFT, turn RIGHT on Vereda Mar de Corazon. We are located inside Torrey Hills Medical and Dental building.
❖ **Heading 5 North or 805 North:** 56 Local Bypass, exit at Carmel Mountain Rd., turn RIGHT, turn RIGHT on third light (Carmel Mtn. Rd), turn RIGHT on Vereda Mar de Corazon. We are located inside Torrey Hills Medical and Dental building.
❖ **Heading 5 South:** Exit Carmel Mountain Rd., turn LEFT, turn RIGHT on fourth light (Carmel Mtn. Rd), turn RIGHT on Vereda Mar de Corazon. We are located inside Torrey Hills Medical and Dental building.



Directions to CHULA VISTA:
1040 Tierra Del Rey, Suite 211, Chula Vista, CA 91910 Phone (619) 656-6785

❖ **Heading 805 South:** exit H Street East, turn RIGHT onto East H St, turn LEFT onto Tierra Del Rey. **O**nce you turn onto Tierra **D**el **R**ey, the **s**treet will **c**ome to a **c**ul-de-**s**ac and we are the **c**orner building on the right (**N**ear the intere**s**ection of Tierra del **R**ey and Canario**s** Ct)
❖ **Heading 805 North:** exit 6 for Telegraph Canyon Rd toward L St, turn RIGHT onto Telegraph Canyon Rd, turn LEFT onto Paseo Del Rey, turn RIGHT onto E H St, turn LEFT onto Tierra Del Rey. **O**nce you turn onto Tierra **D**el **R**ey, the **s**treet will end or **c**ome to a **c**ul-de-**s**ac and we are the **c**orner building on the right (**N**ear the intersection of Tierra del **R**ey and Canario**s** Ct)

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Like Us On facebook

Review us on yelp

Dr. Mr. Mrs. Ms._____ Birthdate _____

Address_____ City, State, ZIP _____

Home or Work #_____ Cell # _____

Email Address _____

Person Financially Responsible _____ Relationship_____

Emergency Contact Person _____ Relationship _____

Emergency Contact Phone # _____ Alternate Phone # _____

MEDICAL HISTORY			DENTAL HISTORY			TMJ HISTORY continued		
Heart Conditions	Yes	No	Latex sensitivity/allergy	Yes	No	Facial pain	Yes	No
High Blood Pressure	Yes	No	Clenching/Bruxing	Yes	No	Ear Problems	Yes	No
Kidney Trouble	Yes	No	Loose/mobile teeth	Yes	No	Vertigo (Dizziness)	Yes	No
Liver disease	Yes	No	Do your gums bleed	Yes	No	Difficulty Chewing	Yes	No
Stroke	Yes	No	Do you have bad breath	Yes	No	**SLEEP HISTORY**		
Diabetes	Yes	No	Do you smoke	Yes	No	Do you snore or been told you do	Yes	No
Neurological Disorders	Yes	No	Do you floss	Yes	No	Do you have difficulty breathing through your nose	Yes	No
Radiation/ Chemotherapy	Yes	No	Does food pack between your teeth	Yes	No	Do you wake up with a headache	Yes	No
Epilepsy/ Seizures	Yes	No				Have you been told you stop breathing while sleep	Yes	No
Psychiatric/Psychological	Yes	No	Tender/Sensitive Teeth	Yes	No	Do you have immediate family members diagnosed/treated with a sleep disorder	Yes	No
AIDS/HIV	Yes	No	**TMJ HISTORY**			Do you have insomnia	Yes	No
Diet Drugs (ex. Phen-Fen)	Yes	No	Migraines/headaches	Yes	No	Have you been more irritable or short tempered	Yes	No
Artificial Joints	Yes	No	Jaw Pain	Yes	No			
Women: Are you pregnant	Yes	No	Jaw Noise or Popping	Yes	No	Have you felt that your memory/intellect is impaired	Yes	No
Women: Are you nursing	Yes	No	Limited Jaw Opening	Yes	No	Do you sleep well	Yes	No

Primary Physician _____ Phone# _____ Fax# _____

List any allergies you have: _____

List medications you are currently taking: _____

_____

Specify any other unlisted medical condition(s) you have: _____

_____

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

_____

_____

_____

Dental Insurance Information

Dental Insurance Name _____ Group Name _____

Member ID Number _____ Group # _____

Policy Holder Information: *(main member of dental plan)*

Name _____

Date of Birth _____

Social Security #_____

Patient Information *(Only if patient is not the policy holder)*

Name _____

Date of Birth _____

Social Security # _____

Patient/Guardian Signature _____ **Date** _____

Initial for no changes to medical history:

Patient	Date	Patient	Date
DMD	Date	DMD	Date
RDH	Date	RDH	Date

CONSENT Please INITIAL next to each of the following items:

_____ **GENERAL CONSENT:** I consent to the following treatment to be done periodically: Exams, X-rays, prophylaxis (teeth cleaning), fluoride, consultations

_____ **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.

_____ **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.

_____ **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.

_____ **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 far you. **H**owever, when an appointment is missed and/ or cancelled without a 48 **HOUR NOTICE**, we reserve the right to charge a **$**50 fee for a regular appointment and a **$**l00 fee for an appointment with a specialist (for each scheduled hour).

_____ **Photographic Release and Consent:** (***optional)*** 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.

HIPAA CALIFORNIA NOTICE

This notice describes how medical/dental information about you may be used and disclosed and how you have access to it.

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" 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. "**D**isclosure" applies to activities outside out office, such as releasing, transferring, or providing access to information about you to other parties. "**A**uthorization" means written permission far 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 of 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 Name_____**Guardian Name** *(if applicable)*_____

Patient/Guardian Signature _____ **Date** _____

Patient _____ **Date** _____ **Patient** _____ **Date** _____ **Patient** _____ **Date** _____

DMD _____ **Date** _____ **DMD** _____ **Date** _____ **DMD** _____ **Date** _____