Highline Dental Care

Patient Medical History Form

Patient's Name:	Today's Date:	ID:(For office use only):

Address:	Date of Last visit:	Date of last Medical Visit:

City,State,Zip :	Email:

Home Phone:	Work Phone:	Cell Phone:	DOB:	SS.NO:	Marital Status:
				- -	

Primary Dental Guarantor:	Home Phone:	Cell Phone :	Work Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

Medical Alerts:

Sex: If female please answer the following:

M

F

Y N Are you taking Birth Control Pills?.

Y N Are you Pregnant?. If yes # of weeks:_____

Y N Are you nursing?.

Please answer the following:

Y N Do you smoke or use Tobacco?.

Height:	Weight:
Office use only: BP:	Office use only: Heart Rate:

Y N Abnormal Bleeding	Y N Glaucoma	Y N Stroke
Y N Alcohol Use	Y N Hay Fever	Y N Thyroid Problems
Y N Allergies	Y N Heart Attack	Y N Tuberculosis
Y N Anemia	Y N Heart Surgery	Y N Ulcers
Y N Angina Pectoris	Y N Hemophilia	Y N Venereal Disease
Y N Arthritis	Y N Hepatitis A	Y N Yellow Jaundice
Y N Artificial Joints	Y N Bisphosphonates (Fosamax,...)	
Y N Artificial Heart Valve	Y N High Blood Pressure	
Y N Asthma	Y N HIV+ AIDS	
Y N Blood Transfusion	Y N Kidney Problems	
Y N Cancer- Chemotherapy	Y N Liver Disease	
Y N Colitis	Y N Low Blood Pressure	
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	
Y N Cosmetic Surgery	Y N Pace Maker	
Y N Diabetes	Y N Pneumocystitis	
Y N Difficulty Breathing	Y N Psychiatric Problems	
Y N Drug Abuse	Y N Radiation Therapy	
Y N Emphysema	Y N Rheumatic Fever	
Y N Epilepsy	Y N Seizures	
Y N Fainting Spells	Y N Shingles	
Y N Fever Blisters	Y N Sickle Cell Disease	
Y N Frequent Headaches	Y N Sinus problem	

Allergies:

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Tetracycline

Other:

_____
_____
_____

Medications:	Reason for taking:	Period of use:

Y N Is there any disease,condition or problem that you think this office should know about that is not covered above?. If yes please describe below:

Notes:

Highline Dental Care

Ardavan Karami DDS &
Neda Karami DDS

General Consent From:

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well , you should be aware that dental treatment ,like treatment of any other part of the body , has some inherent risks.These are seldom great enough to offset the benefits of treatment , but should be considered when making treatment decisions.

Benefits of dental treatment can include : Relief of pain , the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring.
Nonetheless, there are some common risks associated with virtually any dental procedure, including:

- Drug or chemical reaction. Dental materials may trigger allergic or sensitivity reactions.
- Long-term numbness (paresthesia). Local anesthetic,or its administration, while almost always adequate to allow comfortable care, can result in transient,or in rare instances, permanent numbness .
- Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
- Sensitivity in teeth or gums ,infection,or bleeding .
- Swallowing or inhaling small objects.

While we follow procedural guidelines which most often leads to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does.Please free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page.

_____
Patient's signature:

_____
Parent's or Guardian's signature (If minor patient)

_____
Date

Highline Dental Care :

New Patient Information Form

NAME:(Last, First ,Middle):_____ TITLE:_____

ADDRESS:_____

PREFERRED NAME: _____ SS.NO:_____ _____ DOB: / /

HOME PHONE:_____ MARITAL STATUS:_____ REF. DOCTOR:_____

WORK PHONE:_____ SEX: _____ EMAIL:_____

CELL:_____ EMERGENCY CONTACT AND PHONE: _____

MEDICAL ALERTS:_____

PRIMARY DENTAL INSURANCE COVERAGE:

SUBSCRIBER NAME:_____ RELATION TO PATIENT:_____

ADDRESS: _____

SS NO: - - EMPLOYER: _____

DOB: / / ADDRESS:_____

PLAN NAME;_____ GROUP NO:_____ INDIVISUAL YRLY DEDUCT:_____

INSURANCE COMPANY:_____ FAMILY YEARLY DEDUCT:_____

INSURANCE CO ADDRESS:_____ TEL:_____

SECONDARY DENTAL INSURANCE COVERAGE:

SUBSCRIBER NAME:_____ RELATION TO PATIENT:_____

ADDRESS: _____

SS NO: - - EMPLOYER: _____

DOB: / / ADDRESS:_____

PLAN NAME;_____ GROUP NO:_____ INDIVISUAL YRLY DEDUCT:_____

INSURANCE COMPANY:_____ FAMILY YEARLY DEDUCT:_____

INSURANCE CO ADDRESS:_____ TEL:_____

MEDICAL INSURANCE COVERAGE:

SUBSCRIBER NAME:_____ RELATION TO PATIENT:_____

ADDRESS: _____

PLAN NAME;_____ GROUP NO:_____ INDIVISUAL YRLY DEDUCT:_____

RESPONSIBLE PARTY:

NAME AND ADDRESS:_____

SIGNATURE:_____

TODAY'S DATE:_____ WHO SHOULD WE THANK FOR YOUR REFERRAL:_____

Ardavan Karami DDS &
Neda Karami DDS ,P.C

Highline Dental Care

I hereby,authorize designated Highline Dental Care P.C. personnel to use and/or disclose certain PHI about me to or for the third party or parties necessary to complete treatment, Payment and healthcare Operations (TPO). I fully understand that I have the right to review the Highline Dental Care's "Notice of Privacy Practices" prior to signing this consent and Highline Dental Care reserves the right to revise the "Notice of Privacy Practices" at any time and I have the right to request for a revised Notice of Privacy at any time by a written request to Highline dental care,P.C.
By signing this form you authorize Highline Dental Care P.C. To use or disclose the minimum necessary Individually Identifiable Health Information(IIHI) to complete my TPO. This authorization includes all IIHI and PHI unless restricted as delineated below:

Highline Dental Care P.C is authorized to share my PHI with my :

O Spouse/Partner:_____

O Parent(s): _____

O Sibling/ Other: _____

O Under No circumstances should my PHI be shared with :_____

_____

I authorize Highline Dental care to leave a voice message at: _____

O Detailed : (Including treatment done and appointments and follow up necessary)
O General : (Not refer to treatment done or appointments).

---------- I have the right to revoke this authorization at any time in writing addressed to Highline Dental Care P.C except to the extent that Highline Dental Care P.C has already made disclosures in reliance upon my prior request.

Patient's Name:_____
Patient or legal Guardian's Signature:_____

Date:_____

Highline Dental Care

Resin Restoration Consent :

I UNDERSTAND THAT I MAY NEED RESTORATIONS (FILLING ON ONE OR MORE OF MY POSTERIOR (MOLAR AND BICUSPID) TEETH. I ALSO UNDERSTAND THAT THIS OFFICE IS AN AMALGAM FREE OFFICE AND I CONSENT TO THE USE OF RESIN (TOOTH-COLORED) FILLING MATERIAL. I AM AWARE THAT MY INSURANCE MAY NOT PAY THE FULL FEE FOR THIS TYPE OF RESTORATION AND I AM WILLING TO PAY THE DIFFERENCE.

PATIENT NAME

SIGNATURE

DATE