



SAND CANYON DENTAL

MARY GRACE SAMONTE-MORA, D.D.S.
SEPIDEH NAJARAN, D.M.D.

Our Commitment to You

We would like to take this opportunity to thank you for being an important member of our dental practice and to assure you of our continued commitment to excellence in providing dental care for you and your family. We appreciate your understanding in our efforts to maintain respectful guidelines for our practice to keep the caliber of care and service extraordinary.

Treatment

Our goal is to build a long-term relationship with you and to help you in a relaxed and friendly environment. We are committed to providing you with a thorough and complete understanding of your dental condition, so that you can make an informed decision about your treatment. We want to assure you we will be with you every step of the way and welcome any questions you may have.

By initialing this section and signing below, you indicate that you understand and agree to these treatment guidelines.

Initial _____

Financial Arrangements

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are available to answer your questions and assist you in any way we can. We happily accept cash, credit cards (VISA, MasterCard, Discover and American Express). All financial arrangements must be made in advance with a member of our team. Please be prepared to pay any estimated patient portion co-pays at the time treatment is discussed.

I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at time of services unless other arrangements have been made previously. In the event that payments are not made by me or my insurance company on time, I will be held responsible, and a 5% per month late fee shall automatically be added to my account after the account has aged over ninety (90) days.

By initialing this section and signing below, you indicate that you understand and agree to these financial guidelines.

Initial _____

Insurance

We are pleased that you have dental insurance to help you with partial assistance in affording your dental care. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- Insurance is an agreement between you and your insurance company. The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment. Please know that we will do everything possible to see that you receive the full benefits of your policy.

- I agree to authorize assignment of benefits from the insurance company for payment directly to Sand Canyon Dental the expense benefits allowable and otherwise payable to me. This payment shall not exceed my indebtedness to above named assignee and I also agree to pay in a current manner. Any balance of said professional service charges over and above this payment. You will receive a summary of diagnosed treatment this will give you a good idea as to the condition of your mouth, and it will list the approximate costs of having the needed treatment completed. The final analysis and the exact costs will be based on the treatment that was actually completed and the fees routinely charged for such procedures.

By initialing this section and signing below, you indicate that you understand and agree to these insurance guidelines. ***Initial*** _____

Appointments

We pre-plan and prepare for your visit and hope you have done the same. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. When time is lost due to last-minute changes, other patients in need of treatment cannot be seen and your treatment is delayed.

- Should any scheduling changes be required, we require at least 24 hours advance notice during our normal business hours (Monday-Thursday) to avoid a \$75.00 rescheduling fee.

Courtesy Reminder Calls

We consider all appointments confirmed when they are made. As a courtesy, we make every effort to remind patients by telephone prior to their appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, cell phones, pagers, and voice mails, some of our patients may not receive these reminder calls.

- If we are unable to speak with you directly, your appointment card will serve as confirmation and implies your obligation to be present at that prearranged date and time.

By initialing this section and signing below, you indicate that you understand and agree to these appointment guidelines. ***Initial*** _____

We appreciate your understanding in our efforts to provide you with a positive experience.

Patient Signature: _____

Guardian Signature: _____

Date: _____



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PATIENT REGISTRATION

Welcome to our office! We are so glad you have chosen us to meet and exceed your dental expectations! Please take the time needed to complete our patient registration, especially the insurance information if you have not already given it to one of our staff members.

NAME:

Last _____ First _____ MI _____ Preferred _____

Male _____ Female _____ Married _____ Single _____ Child _____ Other _____

Birth Date _____ Social Security No. _____ Driver's License No. _____

Name of Responsible Party _____ Relationship _____

ADDRESS:

Street _____ Apartment No. _____

City _____ State _____ Zip Code _____

Home Telephone No. _____ Employer _____ Work Telephone No. _____ Ext. _____

Pager/Cell No. _____ E-Mail _____

Emergency Contact _____ Telephone No. _____

INSURANCE INFORMATION:

Subscriber _____ Birth Date _____

Social Security Number of Subscriber _____ Policy No. _____

Insurance Company Name _____ Group No. _____

Telephone No. _____

Relationship to Subscriber:

Self _____ Spouse _____ Child _____ Other _____

Employer for Subscriber _____

Who may we thank for referring you to our office? _____



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Patient's name _____

Patient's address _____

Medical Physician's name _____ Date of last visit _____

Emergency Contact _____ Phone _____ Relationship _____

Circle "Yes" or "No" to indicate if you have had any of the following:

| | | | | | | | | |
|--|-----|----|-------------------------|-----|----|----------------------------|-----|----|
| AIDS | yes | no | Headaches | yes | no | Are you nursing? | yes | no |
| Anemia | yes | no | Heart Murmur | yes | no | Psychiatric Care | yes | no |
| Arthritis, Rheumatism | yes | no | Heart Problems | yes | no | Radiation treatment | yes | no |
| Artificial heart Valves | yes | no | Hepatitis | yes | no | Reactions to anesthetic | yes | no |
| Artificial Joints | yes | no | type | | | Respiratory disease | yes | no |
| Asthma | yes | no | Herpes | yes | no | Rheumatic Fever | yes | no |
| Back Problems | yes | no | High Blood Pressure | yes | no | Scarlet Fever | yes | no |
| Bleeding abnormally extractions or surgery | yes | no | Hip/Joint Replacement | yes | no | Shortness of Breath | yes | no |
| Blood Disease | yes | no | HIV Positive | yes | no | Sinus Trouble | yes | no |
| Cancer | yes | no | Jaundice | yes | no | Skin Rash | yes | no |
| Chemical Dependency | yes | no | Jaw Pain | yes | no | Special Diet | yes | no |
| Chemotherapy | yes | no | Kidney Disease | yes | no | Stroke | yes | no |
| Circulatory Problems | yes | no | Liver Disease | yes | no | Swelling of feet or ankles | yes | no |
| Congenital Heart Lesions | yes | no | Low Blood Pressure | yes | no | Thyroid Problems | yes | no |
| Cortisone Treatments | yes | no | Mitral Valve Prolapse | yes | no | Tonsillitis | yes | no |
| Cough, persistent | yes | no | Nervousness | yes | no | Tuberculosis | yes | no |
| Or bloody | yes | no | Osteoporosis/Osteopenia | yes | no | Tumor growth on head | yes | no |
| Diabetes | yes | no | Pacemaker | yes | no | or neck | yes | no |
| Emphysema | yes | no | Pregnant? | yes | no | Ulcer | yes | no |
| Do you wear contact lenses? | yes | no | Due date | | | Venereal Disease | yes | no |
| Epilepsy | yes | no | | | | Weight loss unexplained | yes | no |
| Fainting/dizziness | yes | no | | | | | | |
| Glaucoma | yes | no | | | | | | |

MEDICATIONS

List any medications you are currently taking: _____

ALLERGIES

____ Aspirin ____ Local Anesthetic
____ Codeine ____ Barbituates
____ Sulfa ____ Latex
____ Penicillin

Are you required to Pre-Med prior to dental appointments? Yes No

Do you use recreational drugs? Yes No Other _____

Have you ever taken Fen-Phen? Yes No Other _____

Do you have a history of taking bisphosphonates (Fosamax, Boniva, Didronel, Skelid, Aredia, and Zometa)? **yes no** If yes please circle: **IV Oral**

Patient's Signature _____ Date _____

Parent's or responsible party if minor under 18 (printed name and signature) _____ Date _____

Doctor's Signature _____ Date _____



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Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy policies to gain a clear understanding of how we may use and disclose your PHI.

For Questions concerning our Notice of Privacy Policies, please contact:

Our Office by:

Phone: (949) 727-9077

Fax: (949) 727-9094

Email: sandcanyondental@smileimage.com

Patient's Consent

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ E-Mail _____

I, _____, have read your Notice of Privacy Policies and Dental Material Fact Sheet and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

Patient Signature

Date

If this consent is signed by a personal representative on behalf of the patient, or if the patient would like to give authorization for a personal representative to have access to their medical records please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Contact Information: _____

Address City State Zip

Phone E-mail

Patient/Representative Signature

Date