



# Patient Information Sheet

Chart # \_\_\_\_\_ Office Location \_\_\_\_\_ Date \_\_\_\_\_

## Patient Information

First Name: \_\_\_\_\_ Middle Int. \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mother's Maiden Name: \_\_\_\_\_ Do you:  Rent  Own Do you have a Credit/ Debit Card:  Yes  No  
 Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone #: ( ) \_\_\_\_\_ Cell Phone #: ( ) \_\_\_\_\_ Sex: (M) (F)  
 E-Mail address: \_\_\_\_\_ DL/ ID # \_\_\_\_\_ State: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer: \_\_\_\_\_ Position: \_\_\_\_\_ How Long: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ Work Phone Number: ( ) \_\_\_\_\_ Ext.: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 In Case of Emergency, contact: (Name) \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_ Cell Phone #: ( ) \_\_\_\_\_  
 Relationship: \_\_\_\_\_

How do you intend to pay?  Cash  Credit  Insurance  Medi-Cal  Other \_\_\_\_\_

## Responsible Party

(Disregard if same as above)

Relationship to Patient: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Int. \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mother's Maiden Name: \_\_\_\_\_ Do you:  Rent  Own Do you have a Credit/ Debit Card:  Yes  No  
 Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone #: ( ) \_\_\_\_\_ Cell Phone #: ( ) \_\_\_\_\_ Sex: (M) (F)  
 E-Mail address: \_\_\_\_\_ DL/ ID # \_\_\_\_\_ State: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer: \_\_\_\_\_ Position: \_\_\_\_\_ How Long: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ Work Phone Number: ( ) \_\_\_\_\_ Ext.: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How do you intend to pay?  Cash  Credit  Insurance  Medi-Cal  Other \_\_\_\_\_

## Personal References

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone Number: ( ) \_\_\_\_\_ Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone Number: ( ) \_\_\_\_\_ Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Primary Insurance Information

Insured First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Insured Address: \_\_\_\_\_  
 Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer's Phone Number ( ) \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone Number of Insurance Co.: ( ) \_\_\_\_\_  
 Name of Union and Local Union Number \_\_\_\_\_

## Secondary Insurance Information

Insured First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Insured Address: \_\_\_\_\_  
 Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer's Phone Number ( ) \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
 Insurance Co. Address: \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone Number of Insurance Co.: ( ) \_\_\_\_\_  
 Name of Union and Local Union Number \_\_\_\_\_

I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.  
**I am aware that by signing below I certify that all information is complete and correct. Western Dental may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by law. This is my authorization for Western Dental to verify credit history.**

Signature of Patient

Signature of Responsible Party

## For Office Use Only

VRU Code: \_\_\_\_\_ Date: \_\_\_\_\_ VRU Code: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Employee: \_\_\_\_\_ Form 40A-NV (Rev. 10/07)

# HEALTH HISTORY

DATE \_\_\_\_ - \_\_\_\_ - \_\_\_\_ PATIENT NAME \_\_\_\_\_

AGE \_\_\_\_ SEX M / F HEIGHT \_\_\_\_ WEIGHT LBS. \_\_\_\_

In case of an emergency, contact (person) \_\_\_\_\_

Phone # ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

Facility \_\_\_\_\_ Chart # \_\_\_\_\_

## INSTRUCTIONS:

Answer all questions and fill in the blank spaces when indicated. Answers to the following questions are for our records only and will be kept confidential.

Why are you here today? \_\_\_\_\_  
When was your last visit to a dental office? \_\_\_\_/\_\_\_\_/\_\_\_\_  
PRIOR DENTIST'S NAME and PHONE NUMBER: \_\_\_\_\_

When were your last dental x-rays taken? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Are those x-rays available?  Yes  No  
\_\_\_\_\_ (\_\_\_\_)

- 1. Are you in poor health? .....  Yes  No
- 2. Have you had any serious illness, an operation, or hospitalization in the last 5 years? .....  Yes  No  
If so, what was the problem? \_\_\_\_\_
- 3. Are you pregnant?.....  Yes  No
- 4. Do you have allergies, hives or a skin rash? .....  Yes  No
- 5. Are you allergic to latex or rubber products?.....  Yes  No
- 6. Do you have any blood disorder such as anemia? .....  Yes  No

- 7. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth, head or neck? .....  Yes  No
- 8. Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation? .....  Yes  No
- 9. Do you have or are you being treated for tuberculosis? .....  Yes  No
- 10. Do any of your teeth hurt? Which ones? .....  Yes  No
- 11. Do you wear a partial denture or any other removable dental appliance?.....  Yes  No

- 1. Has there been any change in your general health within the past year? .....  Yes  No
- 2. Are you currently under the care of a physician.....  Yes  No  
A. If so, what is the condition being treated \_\_\_\_\_
- 3. The name and address of my physician is \_\_\_\_\_  
\_\_\_\_\_

- 7. Have you taken the diet medication Redux® (Fen-Phen)? .....  Yes  No
- 8. Are you taking any medications .....  Yes  No  
If yes, indicate which.

- 4. Do you have or have you had any of the following diseases or problems:
  - A. Damaged heart valves or artificial heart valves.....  Yes  No
  - B. Congenital heart lesions or murmurs .....  Yes  No
  - C. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, or other).....  Yes  No
    - 1) Do you have pain in your chest upon exertion? .....  Yes  No
    - 2) Are you ever short of breath after mild exercise? .....  Yes  No
    - 3) Do your ankles swell? .....  Yes  No
    - 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?.....  Yes  No
    - 5) Do you have a cardiac pacemaker? .....  Yes  No
  - D. Low blood pressure .....  Yes  No
  - E. Sinus trouble .....  Yes  No
  - F. Asthma .....  Yes  No
  - G. Emphysema or respiratory problems .....  Yes  No
  - H. Persistent cough or cough up blood.....  Yes  No
  - I. Fainting spells or seizures.....  Yes  No
  - J. Diabetes .....  Yes  No
    - 1) Do you urinate (pass water) more than 6 times a day? .....  Yes  No
    - 2) Are you thirsty much of the time?.....  Yes  No
    - 3) Does your mouth frequently become dry?.....  Yes  No
  - K. Kidney trouble .....  Yes  No
  - L. Stomach troubles/ulcers.....  Yes  No
  - M. Hepatitis, jaundice or liver disease .....  Yes  No
  - N. Sexually transmitted disease .....  Yes  No
  - O. HIV/AIDS .....  Yes  No
  - P. Herpes.....  Yes  No
  - Q. Arthritis or painful, swollen joints .....  Yes  No
  - R. Do you have a prosthetic hip  joint prosthesis   
implants  bone plates  or screws   
other \_\_\_\_\_
- 5. Have you had abnormal bleeding associated with previous surgery, trauma or dental extractions?.....  Yes  No
  - A. Do you bruise easily? .....  Yes  No
  - B. Have you ever required a blood transfusion? .....  Yes  No  
If so, explain the circumstances \_\_\_\_\_
- 6. Do you use or have you used any of the following:
  - 1. Tobacco: smoke \_\_\_\_ smokeless (chewing) \_\_\_\_ .....  Yes  No  
Quantity per day \_\_\_\_\_
  - 2. Alcohol \_\_\_\_ Quantity per day \_\_\_\_ .....  Yes  No
  - 3. Recreational drugs .....  Yes  No

- Antibiotics or sulfa drugs  Anticoagulants (blood thinners)
- Medicine for high blood pressure  Cortisone (steroids)
- Antidepressants  Sedatives  Antihistamines  Aspirin
- Insulin, tolbutamide (orinase) or similar drug
- Digitalis or drugs for heart trouble  Nitroglycerin
- Oral contraceptives or other hormonal therapy
- Medications to treat osteoporosis such as Fosamax, Aredia, Boniva, Zometa (Bisphosphonates)  Herbal remedies
- Any other drug or medicine \_\_\_\_\_

- 9. Are you allergic or have you reacted adversely to any of the following:
  - Local anesthetics .....  Yes  No
  - Penicillin or other antibiotics .....  Yes  No
  - Sulfa drugs .....  Yes  No
  - Barbiturates, sedatives or sleeping pills.....  Yes  No
  - Aspirin.....  Yes  No
  - Iodine.....  Yes  No
  - Codeine or other narcotics.....  Yes  No
  - Nickel or other metals .....  Yes  No
  - Other allergies .....  Yes  No
- 10. Are you wearing contact lenses? .....  Yes  No
- 11. Do you have any problems associated with your menstrual period?  Yes  No
- 12. Are you nursing? .....  Yes  No
- 13. Do you have any disease, condition, or problem not listed above that you think I should know about? .....  Yes  No

## DENTAL HISTORY :

- 14. Is there anything about your teeth or smile that you would like to change? .....  Yes  No  
If so, explain \_\_\_\_\_
- 15. Have you had any serious trouble associated with any previous dental treatment? If so, explain \_\_\_\_\_  Yes  No
- 16. How often do you brush your teeth? \_\_\_\_ When? \_\_\_\_
- 17. How often do you floss? \_\_\_\_ When? \_\_\_\_
- 18. Do your gums bleed or hurt?.....  Yes  No
- 19. Are any of your teeth sensitive to:  
Hot  Cold  Sweets  Pressure  .....  Yes  No
- 20. Does food get caught in your teeth?.....  Yes  No
- 21. Do you have frequent headaches  neck aches   
or shoulder aches?  .....  Yes  No
- 22. Do you clench or grind your teeth?.....  Yes  No
- 23. Have you experienced any pain or soreness in the muscles of your face or around your ear? .....  Yes  No
- 24. Does your jaw click or pop? .....  Yes  No
- 25. Do you wear any type of denture or partial denture? .....  Yes  No
  - A. Date of placement \_\_\_\_/\_\_\_\_/\_\_\_\_
  - B. Is there anything about the denture that you would like to change?  Yes  No

FOLLOW UP to Medical History by DENTIST ONLY \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

SIGNATURE OF PATIENT or Guardian if patient is a minor \_\_\_\_\_ DATE \_\_\_\_ - \_\_\_\_ - \_\_\_\_

SIGNATURE OF DENTIST \_\_\_\_\_ DATE \_\_\_\_ - \_\_\_\_ - \_\_\_\_

DATE	COMMENTS	DR. SIGNATURE	EMPLOYEE#	PATIENT SIGNATURE



NAME \_\_\_\_\_

## HOW DID YOU HEAR OF US ?

ZIP CODE \_\_\_\_\_

OFFICE \_\_\_\_\_

DATE \_\_\_\_\_

**• PLEASE CHECK ONE BOX ONLY !**

- A.  SPANISH T.V.
- B.  ENGLISH T.V.
- C.  SPANISH RADIO
- D.  ENGLISH RADIO
- E.  FLYER / MAILER / COUPON
- F.  NEWSPAPER / MAGAZINE
- G.  SPANISH YELLOW PAGES
- H.  ENGLISH YELLOW PAGES
- I.  BILLBOARD / BUS SIGN
- J.  BUILDING LOCATION SIGN

- K.  FRIEND / NEIGHBOR / RELATIVE
- L.  TELEPHONE / LETTER / RECALL
- M.  DENTAL PLAN REFERRAL
- N.  MANAGED CARE - (GMC, ETC.)
- O.  W.D. VAN 1-800-844-4444
- P.  W.D. BOOTH (SWAPMEET, SPECIAL EVENT, ETC.)
- Q.  INTERNET
- R.  **W.D. DENTIST**
- S.  **W.D. ORTHODONTIST**

Form 232-NV (Rev. 7/97)



NOMBRE \_\_\_\_\_

## COMO SE ENTERO DE NOSOTROS ?

ZONA \_\_\_\_\_

OFICINA \_\_\_\_\_

FECHA \_\_\_\_\_

**¡ POR FAVOR MARQUE UN CUADRO SOLAMENTE !**

- A.  TELEVISIÓN EN ESPAÑOL
- B.  TELEVISIÓN EN INGLÉS
- C.  RADIO EN ESPAÑOL
- D.  RADIO EN INGLÉS
- E.  VÓLANTES / CORREO / CUPONES
- F.  PERIÓDICO / REVISTAS
- G.  GUÍA TELEFÓNICA EN ESPAÑOL
- H.  GUÍA TELEFÓNICA EN INGLÉS
- I.  CARTELERA / ANUNCIOS EN AUTO BUSES
- J.  LUGAR DEL EDIFICIO

- K.  AMIGOS / VECINOS / RELATIVO
- L.  AVISO POR TELÉFONO / CARTA
- M.  REFERENCIAS PARA PLAN DENTAL
- N.  MANAGED CARE (GMC, ETC.)
- O.  CAMIÓN W.D. 1-800-844-4444
- P.  CASILLA W.D. (SWAPMEET, EVENTO ESPECIAL, ETC.)
- Q.  INTERNET
- R.  **DENTISTA W.D.**
- S.  **ORTODONTISTA W.D.**



Dear Patient,

In keeping with the standards of the profession and the recent developments in sterilization and infection control, we at Western Dental have formulated this general public information bulletin to give our patients an idea of how seriously we take the safety and well being of our patients.

- 1) All doctors, hygienists and assistants wear gloves, masks, and face shields or goggles.
- 2) Doctors and assistants wash their hands and change gloves with every patient.
- 3) Dental drill handpieces are cleaned, bagged and sterilized prior to use on each patient.
- 4) All instruments are scrubbed, cleaned, bagged and sterilized according to guidelines set forth by the Center for Disease Control & Prevention.
- 5) All instruments are sterilized in autoclaves or chemical vapor sterilizers according to recommended procedures. If the instruments are heat sensitive, an overnight (10 + hours) sterilized soak is done.
- 6) Western Dental tests all sterilizers weekly and this is confirmed through independent lab analysis.
- 7) All operating surfaces are cleaned with EPA registered hospital grade surface disinfectants.
- 8) Many disposable items are used. Once used, they are discarded. Some examples are the injection needles, plastic suction tips and the polishing cups.
- 9) An independent company has been retained to vaccinate and test our staff for the Hepatitis B virus.
- 10) Our staff, while taking x-rays, always use fresh gloves and each x-ray holder is individually bagged and sterilized.
- 11) Infection control seminars are held for all our dental offices throughout the year.
- 12) Our company has retained an infection control consultant who randomly inspects our offices on a routine basis. Many of these inspections are done on a "surprise" basis to ensure that the offices are following accepted guidelines. In addition to these inspections, our own administrative staff performs regularly scheduled audits on all our offices.

Western Dental provides dental care services without discrimination based on race, religion, color, national origin, sex, sexual orientation, physical or mental disability, age or marital status and protects the privacy of each of its patients. If any questions or concerns arise regarding the dental care, treatment or services you have received, contact Western Dental at 1-800-992-3366 or write to Western Dental, P.O. Box 14227, Orange, California, 92863.



FARIBA TABIBI, D.D.S.

# ARBITRATION AGREEMENT

Patient Chart No. \_\_\_\_\_

Patient Name: \_\_\_\_\_

Office Location: \_\_\_\_\_

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must Be Arbitrated:** It is the intention and agreement of the parties that this arbitration agreement shall cover all claims or controversies relating to the matters described in Article 1 above, except claims within the jurisdiction of the Justice Court, whether in tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described in Article 1 may arise out of or in any way relate to treatment or services provided or not provided by Fariba Tabibi, D.D.S., P.C. dba Western Dental of Nevada and/or Fariba Tabibi, D.D.S., P.C. dba Western Dental (collectively, "Western") or any employee or agent or providers of Western, including any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. The undersigned understands and agrees that if the undersigned signs this Contract on behalf of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person.

The reference to Western includes Fariba Tabibi, D.D.S., P.C., Western Dental of Nevada, LLC, and their respective employees, agents and providers. Filing any action in any court by Western to collect any fee from Patient shall not waive the right to compel arbitration of any claim described in Article 1. However, following the assertion of any claim against Western, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by the same arbitration.

**Article 3: Procedures and Applicable Law:** Patient shall initiate arbitration by serving a Demand for Arbitration on Western and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: Fariba Tabibi, D.D.S., P.O. Box 14025, Orange, CA 92863-1025, Attention: Legal Department. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient and his/her attorney. Patient and Western agree that any arbitration hereunder shall be conducted by a single, neutral arbitrator selected by the parties and shall be resolved using the rules of the American Arbitration Association. (Arbitration, however, shall not be conducted by the American Arbitration Association.) Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to N.R.S. §§ 38.206 et seq. and the Federal Arbitration Act (9 U.S.C. §§ 1- 9), as in effect from time to time.

**Article 4: Retroactive Effect:** Patient intends this Contract to cover services rendered by Western not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

**Article 5: Severability:** If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this Contract. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

\_\_\_\_\_ Dated: \_\_\_\_\_, 20 \_\_\_\_\_

Print Patient's Name (Signature of Patient, Parent, Guardian or Legally Authorized Representative of Patient)

### WESTERN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing agreements under this Contract, Western likewise agrees to be bound by the terms set forth in this Contract and to the rules specified in Article 3 above.

\_\_\_\_\_ Prepared By Western Employee \_\_\_\_\_ Print Name \_\_\_\_\_ Date Signed

A signed copy of this document is to be given to Patient. The Original is to be filed in Patient's dental chart.