

Patient Information

First Name: _____ MI: _____ Last Name: _____ DOB: _____
 Zip: _____ Home Address: _____ Apt #: _____ City: _____ State: _____
 Home Phone #: _____ Cell Phone #: _____ Sex: M F
 E-Mail Address: _____ DL/ID #: _____ State: _____ Type: _____ SSN: _____
 Employer: _____ Position: _____ How Long: _____ years _____ months
 Employer Address: _____ Work Phone Number: _____ Ext.: _____
 City: _____ State: _____ Zip: _____
 Medical Insurance Carrier _____ Are you / have you had a contract with Western Dental? Yes No
 Spouse First Name: _____ Last Name: _____ Home Phone #: _____ Cell: _____

Responsible Party (Disregard if same as above)

Relationship to Patient: _____
 First Name: _____ MI: _____ Last Name: _____ DOB: _____
 Zip: _____ Home Address: _____ Apt #: _____ City: _____ State: _____
 Home Phone #: _____ Cell Phone #: _____ Sex: M F
 E-Mail Address: _____ DL/ID #: _____ State: _____ Type: _____ SSN: _____
 Employer: _____ Position: _____ How Long: _____ years _____ months
 Employer Address: _____ Work Phone Number: _____ Ext.: _____
 City: _____ State: _____ Zip: _____
 Medical Insurance Carrier _____

Emergency Contacts

Contact # 1 First Name: _____ Last Name: _____ Relation: _____
 Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____ Ext: _____
 Home Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
 How many years have you known this person? _____
Contact # 2 First Name: _____ Last Name: _____ Relation: _____
 Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____ Ext: _____
 Home Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
 How many years have you known this person: _____
Contact # 3 First Name: _____ Last Name: _____ Relation: _____
 Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____ Ext: _____
 Home Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
 How many years have you known this person: _____

Primary Insurance Information

Insured First Name: _____ Last Name: _____ Date of Birth: _____
 Home Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
 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 _____ Phone Number of Insurance Co. _____
 Insurance Co. Address _____ Effective Date: _____
 Group #: _____ Policy #: _____ Name of Union and Local Union Number _____

Secondary Insurance Information

Insured First Name: _____ Last Name: _____ Date of Birth: _____
 Home Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
 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 _____ Phone Number of Insurance Co. _____
 Insurance Co. Address _____ Effective Date: _____
 Group #: _____ Policy #: _____ Name of Union and Local Union Number _____

Financial Responsibility

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.

Verification and Collections

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), contact information, and social security number to the extent permitted by law. This is my authorization for Western Dental to verify identity and credit history. By providing Western Dental with my cell phone number, I consent to receiving autodialed and prerecorded message calls from Western Dental or its third party debt collector at that number and at any cell phone numbers I provide in the future.

Consent to Record, Video and Audio

I authorize Western Dental and its employees, agents, and representatives to film and record today's patient visit and treatment, and all future patient visits and treatment for use by Western Dental for its health care operations, including, but not limited to: quality assessment and improvement activities, including case management and care coordination; competency assurance activities; conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; business planning, development, management, and administration; and business management and general administrative activities.

Signature of Patient: _____ Signature of Responsible Party: _____

For Office Use Only

Date: _____ Other WDS contracts: _____ Signature of Employee: _____



HEALTH HISTORY

Date (MM/DD/YYYY)

Chart Number

Instructions: Answer all of the questions on this form. Examples of markings:

Good Samples



Bad Samples



Patient First Name

MI

Last Name

Age

Height (feet - inches)

Weight (lbs)

Primary Phone #

Gender

Male

Female

In case of any emergency, contact (person)

Why are you here today?

When was your last visit to a dental office?

When were your last dental x-rays taken?

Are those x-rays available?

Yes

No

Prior Dentist Name

Prior Dentist Phone #

- 1. Are you in good health? Yes No
- 2. Have you had any serious illness, an operation, or hospitalization in the last 5 years? (Describe on page 3) Yes No
- 3. Have there been any changes in your general health within the past year? Yes No
- 4. Are you currently under the care of a physician? (Describe on page 3) Yes No

- 18. Ankles swell Yes No
- 19. Shortness of breath when you lie down, or you require extra pillows when you sleep Yes No
- 20. A cardiac pacemaker Yes No
- 21. Low blood pressure Yes No
- 22. Sinus trouble Yes No
- 23. Asthma Yes No

Do you have or have you had any of the following diseases or conditions?

- 5. Damaged heart valves or artificial heart valves Yes No
- 6. Congenital heart lesions or murmurs Yes No
- 7. High blood pressure Yes No
- 8. Heart attack Yes No
- 9. Coronary insufficiency Yes No
- 10. Coronary occlusion Yes No
- 11. Arteriosclerosis Yes No
- 12. Stroke Yes No
- 13. Coronary bypass Yes No
- 14. Coronary artery shunt Yes No
- 15. Other cardiovascular disease/condition Yes No
- 16. Pain in your chest upon exertion Yes No
- 17. Shortness of breath after mild exercise Yes No

- 24. Emphysema or respiratory problems Yes No
- 25. Tuberculosis Yes No
- 26. Persistent cough or cough up blood Yes No
- 27. Fainting spells or seizures Yes No
- 28. Diabetes Yes No
- 29. Urination (pass water) more than 6 times a day Yes No
- 30. Thirsty much of the time Yes No
- 31. Mouth frequently becomes dry Yes No
- 32. Kidney trouble Yes No
- 33. Stomach troubles/ulcers Yes No
- 34. Hepatitis, jaundice or liver disease Yes No
- 35. Sexually transmitted disease Yes No
- 36. HIV/AIDS Yes No
- 37. Herpes Yes No

Current Physician's Name

Current Physician's Phone #

Address

Suite#

City

State

Zip Code



HEALTH HISTORY

38. Arthritis or painful, swollen joints Yes No

39. Lupus /Autoimmune disease Yes No

40. Prosthetics (Check all that apply)

- A. NONE
- B. Prosthetic hip
- C. Implant
- D. Bone Screw
- E. Joint prosthesis
- F. Bone plate
- G. Other (Describe on page 3)

41. Blood disorder such as anemia Yes No

42. Abnormal bleeding associated with previous surgery, trauma or dental extractions Yes No

43. Bruise easily Yes No

44. Have you ever required a blood transfusion? (Describe on page 3) Yes No

Do you use or have you used any of the following:

45. Tobacco: smoking

- A. No
- B. Less than one pack a day
- C. One pack a day
- D. More than one pack a day

46. Tobacco: chewing

- A. No
- B. Less than once a day
- C. Once a day
- D. More than once a day

47. Alcohol

- A. No
- B. Less than one drink a day
- C. One drink a day
- D. More than one drink a day

48. Recreational drugs Yes No

49. Have you taken the diet medication Redux (Fen-Phen)? Yes No

50. Are you taking any medications? (Check all that apply)

- A. Antibiotics or sulfa drugs
- B. Medicine for high blood pressure
- C. Antidepressants
- D. Antihistamines
- E. Insulin, tolbutamide (orinase) or similar
- F. Nitroglycerin
- G. Medicine for osteoporosis: Fosamax, Aredia, Boniva, Zometa (Bisphosphonates)
- H. Anticoagulants (blood thinners)
- I. Cortisone / Prednisone (steroids)
- J. Sedatives
- K. Aspirin
- L. Digitalis or drugs for heart trouble
- M. Oral contraceptives or other hormonal therapy
- N. Herbal remedies (Describe below)
- O. Any other drug or medicine? (Describe on page 3)
- P. NONE

51. Are you allergic or have you reacted adversely to any of the following? (Check all that apply)

- A. Local anesthetics
- B. Medicine for high blood pressure
- C. Sulfa drugs
- D. Aspirin
- E. Codeine or other narcotics
- F. Latex
- G. Penicillin or other antibiotics
- H. Cortisone / Prednisone (steroids)
- I. Barbiturates, sedatives or sleeping pills
- J. Iodine
- K. Nickel or other metals
- L. Other allergies (Describe on page 3)
- M. NONE

52. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or head? Yes No

53. Have you had chemotherapy treatment for cancer or any other disease? (Describe on page 3) Yes No

54. Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation? Yes No

55. Are you wearing contact lenses? Yes No

56. Do you have any problems associated with your menstrual period? Yes No

57. Are you pregnant? Yes No

58. Are you nursing? Yes No

59. Do any of your teeth hurt? (Describe on page 3) Yes No

60. How often do you brush your teeth? (Check one)

- A. Less than once a day
- B. Once a day
- C. More than once a day

61. When do you brush your teeth? (Check all that apply)

- A. Morning
- B. Evening
- C. After meals

62. How often do you floss? (Check one)

- A. Never
- B. Occasionally
- C. Once a day

63. Do your gums bleed or hurt? Yes No

64. Are any of your teeth sensitive to? (Check all that apply)

- A. Hot
- B. Sweets
- C. Cold
- D. Pressure
- E. NONE



HEALTH HISTORY

65. Does food get caught in your teeth? Yes No

66. Do you have? (Check all that apply)

- A. Frequent headaches
- B. Neck aches
- C. Shoulder aches
- D. NONE

67. Do you clench or grind your teeth? Yes No

68. Have you experienced any pain or soreness in the muscles of your face or around your ear? Yes No

69. Does your jaw click or pop? Yes No

70. Is there anything about your teeth or smile that you would like to change? (Describe below) Yes No

71. Do you wear a partial denture, full denture or any other removable dental appliance? Yes No

72. Is there anything about your partial denture, full denture or any other removable dental appliance that you would like to change? (Describe below) Yes No

Additional comments & descriptions

What was the illness, operation or hospitalization in the last 5 years from question 2?

What is the condition for which you are currently under the care of a physician from question 4?

What other implants or prostheses do you have from question 40?

What were the circumstances of your blood transfusion from question 44?

What other drugs or medicine do you take from question 50?

To what other drugs/materials are you allergic to or have you reacted adversely from question 51?

For what cancer or other disease have you had chemotherapy from question 53?

Which of your teeth hurt from question 59?

Is there anything about your teeth or smile that you would like to change from question 70?

Is there anything about your partial denture, full denture or any other removable dental appliance that you would like to change from question 72?

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

Signature of PATIENT or GUARDIAN _____
if patient is a minor

Date / /

Signature of DENTIST _____ ID#

Date / /

UPDATE

Have there been any changes in your medical history, including any medications that you take, since you last completed this form? Yes No

Signature of PATIENT or GUARDIAN _____
if patient is a minor

Dr. Signature _____

Date _____

Date _____



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.