

NEW PATIENT REGISTRATION

Dr. Amir Sadjadi, D.M.D.

RESPONSIBLE PARTY (if someone other than patient)

Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Today's Date: _____

Home Address: _____ Address 2: _____

City, State, Zip: _____ Work phone: _____/_____/_____

Cell phone (with area code): _____/_____/_____ Home Phone: _____/_____/_____

Email: (please print) _____

Birth Date: (Mo, Day, Year): _____ Soc. Sec. # _____/_____/_____

Responsible Party is also a (circle): Policy holder for patient Primary Insurance Policy holder Secondary Insurance Policy holder

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Today's Date: _____

Home Address: _____ Address 2: _____

City, State, Zip: _____ Work phone: _____/_____/_____

Cell phone (with area code): _____/_____/_____ Home Phone: _____/_____/_____

Email: (please print) _____

Birth Date: (Mo, Day, Year): _____ Soc. Sec. # _____/_____/_____

WAS INSURANCE OBTAINED PERSONALLY ☐ OR THROUGH EMPLOYER? ☐ (tick one)

PLEASE REPEAT HOME ADDRESS IF INSURANCE WAS OBTAINED PERSONALLY AND NOT THROUGH EMPLOYER

Employer (company) name: _____

NAME, BIRTHDATE OF PRINCIPAL POLICYHOLDER

Employer (or home) address: _____

(CITY, ZIP)

Employer phone (with area code): _____/_____/_____ Status (circle): Full-time Part-time Retired

PRIMARY INSURANCE INFORMATION

Name of insurance company: _____

Name of policyholder: _____ Relationship to insured (circle) Self Spouse Child Other

Insured Soc. Sec. # _____/_____/_____ Insured Birth Date: _____/_____/_____

SECONDARY INSURANCE INFORMATION (IF ANY)

Name of insurance company: _____

Name of policyholder: _____ Relationship to insured (circle) Self Spouse Child Other

Insured Soc. Sec. # _____/_____/_____ Insured Birth Date: _____/_____/_____

PATIENT COVID-19 SCREENING FORM

Patient Name: _____

Date: _____

Do you have fever or have you felt hot or feverish recently (14-21 days)?	Yes ☐	No ☐
Are you having shortness of breath or other difficulties breathing?	Yes ☐	No ☐
Do you have a cough?	Yes ☐	No ☐
Do you have any other flu-like symptoms, such as gastro-intestinal upset, headache or fatigue?	Yes ☐	No ☐
Have you experienced recent loss of taste or smell?	Yes ☐	No ☐
Are you in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-10 should consider postponing the appointment.</i>	Yes ☐	No ☐
Is your age over 60?	Yes ☐	No ☐
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes ☐	No ☐
Have you traveled in the past 14 days to any regions affected by COVID-19?	Yes ☐	No ☐

Patient signature _____

NEW PATIENT MEDICAL HISTORY

Patient First Name: _____

Patient Last Name: _____

Patient's Birth Date (Mo, Day, Year): ____/____/____

Today's Date: ____/____/____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? (circle).....Yes	No	If Yes, please explain _____
Have you ever been hospitalized or had a major operation? (circle).....Yes	No	If Yes, please explain _____
Have you ever had a serious head or neck injury? (circle).....Yes	No	If Yes, please explain _____
Are you taking any medications, pills or drugs? (circle).....Yes	No	If Yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux? (circle).....Yes	No	If Yes, please explain _____
Have you ever taken Fosamax, Boniva, Actonel or any other		
medications containing bisphosphonates (circle).....Yes	No	If Yes, please explain _____
Are you on a special diet? (circle).....Yes	No	If Yes, please explain _____
Do you use tobacco? (circle).....Yes	No	If Yes, please explain _____
Do you use controlled substances? (circle).....Yes	No	If Yes, please explain _____

Women, are you: (circle) Pregnant/trying to get pregnant? Yes No Taking oral contraceptives Yes No Nursing? Yes No

Are you allergic to any of the following? (circle)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs

Other: if other, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive..... Yes	No	Diabetes..... Yes	No	Hepatitis B or C.....Yes	No	Rheumatic Fever.....Yes	No
Alzheimer's Disease..... Yes	No	Drug Addiction..... Yes	No	Herpes.....Yes	No	Rheumatism.....Yes	No
Anaphylaxis..... Yes	No	Easily Winded..... Yes	No	High Blood Pressure.....Yes	No	Scarlet Fever.....Yes	No
Anemia..... Yes	No	Emphysema..... Yes	No	High Cholesterol.....Yes	No	Shingles.....Yes	No
Angina..... Yes	No	Epilepsy or Seizures..... Yes	No	Hives or Rash.....Yes	No	Sickle Cell Disease.....Yes	No
Arthritis/Gout..... Yes	No	Excessive Bleeding..... Yes	No	Hypoglycemia.....Yes	No	Sinus Trouble.....Yes	No
Artificial Heart Valve..... Yes	No	Excessive Thirst..... Yes	No	Irregular Heartbeat.....Yes	No	Spina Bifida.....Yes	No
Artificial Joint..... Yes	No	Fainting Spells/Dizziness..... Yes	No	Kidney Problems.....Yes	No	Stomach/Intestinal Disease.....Yes	No
Asthma..... Yes	No	Frequent Cough..... Yes	No	Leukemia.....Yes	No	Stroke.....Yes	No
Blood Disease..... Yes	No	Frequent Diarrhea..... Yes	No	Liver Disease.....Yes	No	Swelling of Limbs.....Yes	No
Blood Transfusion..... Yes	No	Frequent Headaches..... Yes	No	Low Blood Pressure.....Yes	No	Thyroid Disease.....Yes	No
Breathing Problem..... Yes	No	Genital Herpes..... Yes	No	Lung Disease.....Yes	No	Tonsillitis.....Yes	No
Bruise Easily..... Yes	No	Glaucoma..... Yes	No	Mitral Valve Prolapse.....Yes	No	Tuberculosis.....Yes	No
Cancer..... Yes	No	Hay Fever..... Yes	No	Osteoporosis.....Yes	No	Tumors or Growths.....Yes	No
Chemotherapy..... Yes	No	Heart Attack/Failure..... Yes	No	Pain in Jaw Joints.....Yes	No	Ulcers.....Yes	No
Chest Pains..... Yes	No	Heart Murmur..... Yes	No	Parathyroid Disease.....Yes	No	Venereal Disease.....Yes	No
Cold Sores/Fever Blisters..... Yes	No	Heart Pacemaker..... Yes	No	Psychiatric Care.....Yes	No	Yellow Jaundice.....Yes	No
Congenital Heart Disease..... Yes	No	Heart trouble/disease..... Yes	No	Radiation Treatments.....Yes	No		
Convulsions..... Yes	No	Hemophilia..... Yes	No	Recent Weight Loss.....Yes	No		
Cortisone Medicine..... Yes	No	Hepatitis A..... Yes	No	Renal Dialysis.....Yes	No		

Have you ever had any serious illness not listed above? (circle) Yes No If Yes, please explain: _____

Comments: _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

PATIENT SIGNATURE

Date

TREATING DENTIST'S SIGNATURE

UPDATED SIGNATURE

Date

UPDATED SIGNATURE

Date

NEW PATIENT DENTAL HISTORY

Dr. Amir Sadjadi, D.M.D.

Patient First Name: _____

Patient Last Name: _____

Reason for Today's Visit: _____

Date of last dental examination: (approximate if not recalled) _____

Was any treatment rendered other than a cleaning? (circle) Yes No

Are you currently experiencing dental discomfort? (circle) Yes No

Are any of your teeth sensitive to the following? (circle) Hot Cold Sweet Pressure Other (please explain)

Are you apprehensive about dental treatment? (circle) Yes No

Are you aware of your jaw making clicking or popping noises? (circle) Yes No

Do your jaw muscles feel tired, stiff or painful? (circle) Yes No

Are you aware of clenching or grinding your teeth? (circle) Yes No

If yes, when do you clench or grind? (circle) Daytime During the night or other

Do you wear a nightguard? (circle) Yes No

Have you ever had orthodontic treatment (braces)? (circle) Yes No

Do you wear orthodontic retainers? (circle) Yes No

Are you pleased with the appearance of your teeth? (circle) Yes No

If not, what are you dissatisfied with? (circle) Color Alignment Shape Stains

Other (please explain) _____

Have you ever had periodontal treatment or gum surgery? (circle) Yes No

If yes, how long ago? [Click here to enter text.](#)

Have you ever been informed that you have gum disease? (circle) Yes No

Are you experiencing any of the following? (circle) Receding gumline Gums bleed easily Red/swollen gum tissue

Other (please explain) _____

Do you have any areas where you shred food or impact food? (circle) Yes No

Are you aware of a bad taste or odor in your mouth? (circle) Yes No

Have you ever had any teeth extracted? (circle) Yes No

If yes, what was the reason? (circle) Wisdom teeth Orthodontics Other (please explain) _____

Have you had dental implants placed? (circle) Yes No

If yes, when were the implants placed? _____

Do you wear removable appliances? (circle) Yes No Full Upper Denture Partial Upper Denture

Full Lower Denture Partial Lower Denture

Has anyone ever suggested implants as an alternative treatment for your denture or partial? Yes No

END FORM

DENTAL TREATMENT CONSENT FORM

Patient name _____

Date of birth _____

Please read and initial the items checked below. Then read and sign the section at the bottom. Thank you.

WORK TO BE DONE: I understand that I am having the following work done: ☐ Exam ☐ X-Rays ☐ Regular cleaning
☐ Fillings ☐ Extractions ☐ Removal of impacted teeth ☐ General Anesthesia ☐ Root Canal

(initials) _____

☐ **DRUGS & MEDICATIONS** I understand that antibiotics and analgesics and other medications can cause allergic reactions, causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

(initials) _____

☐ **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 examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(initials) _____

☐ **REMOVAL OF TEETH** Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth: _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to undergo further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(initials) _____

☐ **CROWNS, BRIDGES AND CAPS** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size and color) will be before cementation.

(initials) _____

☐ **DENTURES, COMPLETE OR PARTIAL** I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The possible problems in wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the denture fee.

(initials) _____

☐ **ENDODONTIC TREATMENT (ROOT CANAL)** I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

(initials) _____

☐ **PERIODONTAL LOSS (TISSUE AND BONE)** I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(initials) _____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

(initials) _____

Signature of Patient, Parent, Guardian or Personal Representative

Date

Dr. Amir Sadjadi, DMD

4950 Barranca Pkwy
Irvine, CA 92604

GENERAL DENTISTRY CARE CONSENT

Patient name: _____

Date of Birth: _____

Welcome to our clinic. We appreciate the confidence you have placed with us to provide your dental care.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

For the best results it is imperative that I work together with the dental care team. This means that I will strive to keep all appointments and arrive on time. Cooperation and participation are essential for the desired outcome.

I understand the dental care team will recommend procedures. They will do their best to make sure I understand their care and plan. If I do not understand any of the treatments or the plan I will discuss it with the dental team. I understand that if I do not fulfill my part of the agreement by following their advice I will be hampering the outcome of my treatment.

I understand that should I feel there are changes in my condition, or symptoms should appear between scheduled visits I should notify the office immediately.

Signature of patient, parent, guardian or personal representative

Date

Patient name, printed

MINOR CONSENT FORM

Childs' Name _____ Date _____

Child's Date of Birth _____

Your child is in need of some basic dental care. This form explains the care that your child needs, and requests your permission to provide that care. Please check the appropriate box(es).

☐ **Dental Exam, X-rays and Regular Teeth Cleaning**

☐ **Dental Fillings:** _____ tooth/teeth

Decay dissolves the tooth, and if not treated, will result in an abscessed tooth causing pain and infection. The dentist will remove the decayed and weakened part of the tooth and replace it with a silver alloy or tooth-colored material to strengthen the tooth. A local anesthetic may be used that will "numb" the area being treated for one or two hours.

☐ **Sealants:** _____ tooth/teeth

Back teeth have grooves and pits in which decay usually starts. The dentist or hygienist will "seal" the grooves with a plastic coating to help prevent the decay from starting. No anesthetic is needed.

☐ **Stainless Steel Crowns:** _____ tooth/teeth

If a tooth is badly destroyed by decay a filling will not stay in place. Therefore, a tooth is trimmed around the sides and a preformed crown or "cap" is placed over the tooth to protect it from breaking. As with fillings, the area is usually treated with an anesthetic to help the child remain comfortable for one or two hours.

☐ **Nerve or Pulp Treatment:** _____ tooth/teeth

When the decay or infection progresses far enough that the tissue inside the tooth is infected all or part of that infected tissue must be removed and a special filling placed there in order to keep the infection from spreading to other parts of the body. The treatment usually takes at least two visits during which an anesthetic will be used. Pain or swelling after this work is rare and usually minor. Antibiotics may be used to control possible infections. After treatment a filling or crown will be placed over the tooth to help strengthen it and keep it from breaking.

☐ **Extraction or Removal of the tooth:** _____ tooth/teeth

If an infection has spread too far to rebuild the tooth it is often best to remove the tooth to prevent infection from spreading farther. After numbing the area with anesthetic the tooth is removed and the area packed with gauze to control bleeding. Care should be taken not to rinse for a couple of hours or bleeding may begin again. Biting on gauze or towels will usually stop the bleeding. Pain or swelling after this work is rare and usually minor.

☐ **Nitrous Oxide and/or Premedication:** _____ tooth/teeth

If a child is particularly nervous about dental treatment the dentist may use "laughing gas" (nitrous oxide) or some medication to help relax the child so the work can be done properly. The medications may cause the child to be drowsy after the appointment. We expect the child will need approximately _____ appointments to complete this work.

I understand that my child _____ needs to receive the dental treatments checked above.

☐ I give my consent for all these services

☐ I give my consent for all these services except _____

☐ I do not give my consent for any of these services

☐ My consent for these services expires _____

Name of parent/guardian (please print)

Date

Signature

PEDIATRIC (children's) INFORMED CONSENT

Patient name: _____ Date of birth: _____

You have the right and obligation to make decisions regarding your healthcare and the care provided to your child. Your cooperation and participation in the decision-making process is necessary. When providing dental care to a child special circumstances may arise.

1. **Preventing injury:** The most difficult issue when treating children is controlling the child so that no injury accidentally occurs to the child as a result of an abrupt movement. In some cases it might be recommended the child be sedated prior to the treatment. Additionally, various restraining devices may also be necessary to ensure the safety of the patient and the dental care team during treatment.
2. **Numbness in the tongue, lips, jaw and/or facial tissue resulting from the administration of local anesthetic.** Numbness may be present following treatment. During the period of time there is numbness the child should be monitored and reminded not to bite or chew on the numb area and be careful drinking liquids. Any numbness which appears to last longer than 24 hours should be reported immediately to the dental care team.

Below are some common occurrences in pediatric dentistry:

- **Cavities in children** Because of the nature of deciduous (baby) teeth, coupled with difficulty in brushing and flossing regularly, cavities can occur very quickly. Special care is needed to avoid these problems. Preventive measures include fluoride treatments, placing sealants, thorough brushing, flossing, control of sweets and acids in the diet, coupled with regular dental checkups.
- **Fractures and broken teeth** Due to the fragility of the deciduous (baby) teeth it can be difficult to secure large fillings in these teeth. If the child's tooth is unable to retain a filling or if the cavities are initially large, the dental care team may recommend the placement of crowns on the teeth in order to preserve them until the teeth fall out as a result of the maturity process.
- **Pulpotomy** is a treatment where the pulp tissue in the upper part of the tooth is removed and replaced with various filling materials so the tooth is preserved, space is maintained as well as chewing ability until the permanent tooth replaces the deciduous tooth. The dental care team may recommend this procedure due to the thinness of the enamel of the deciduous tooth or rapid decay in the teeth. However, in spite of these efforts to save the tooth, extraction may still become necessary.
- **Abscesses** Deciduous (baby) teeth are particularly susceptible to abscesses. Abscesses can occur if the pulp tissue of the tooth has become infected. This is a very painful event with swelling. Abscesses can occur as a result of traumatic injury to a tooth as well. The office should be contacted immediately if you suspect an abscess.
- **Extraction and space maintenance** It may be impossible to save a tooth so the dental care team may recommend extraction. Maintenance of space is important for the permanent teeth. Therefore it may become necessary to insert an appliance known as a space maintainer. These devices can either be fixed or removable.

PEDIATRIC (children's) INFORMED CONSENT

Patient name: _____ Date of birth: _____

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NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose it.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by on or more healthcare providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any

other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2021 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information.

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
Toll-free (800) 368-1019

Dr. Amir Sadjadi, D.M.D., P.C.

4950 Barranca Pkwy, #304

Irvine, CA 92604

(949) 861-8441

**ACKNOWLEDGEMENT of RECEIPT of NOTICE
of PRIVACY PRACTICES**

I, (please print) _____, have viewed a copy
of this office's Notice of Privacy Practices.

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Practices, but
acknowledgement could not be obtained because:

- ☐ Individual refused to sign
 - ☐ Communications barriers prohibited obtaining the acknowledgement
 - ☐ An emergency situation prevented us from obtaining acknowledgement
 - ☐ Other (please specify) _____
-

Dr. Amir Sadjadi, D.M.D., P.C.

4950 Barranca Pkwy, #304

Irvine, CA 92604

(949) 861-8441

**Patient Acknowledgement of
Dental Materials Fact Sheet**

I, (please print) _____, acknowledge I have
viewed a copy of this office's Dental Materials Fact Sheet dated October 2001.

Signature

Date

The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Materials Fact Sheet, and its linkage to the DCA website does not constitute an endorsement of the content of this document.

**The Dental Board of California
Dental Materials Fact Sheet**

Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam, composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials". A "Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993-2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth its longevity will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Dr. Amir Sadjadi
General, Cosmetic & Surgical Family Dentistry
4950 Barranca Pkwy, #304
Irvine, CA 92604
Phone (949) 861-8441

PATIENT FINANCIAL RESPONSIBILITY

When patients carry dental insurance, charges for services rendered are billed to the insurance company. The patient is charged with his/her co-pay amount, if any, plus a deductible, if any exists in the patient's plan.

I, the patient, understand that whatever the outcome of the insurance claim, I am responsible for payment of any and all charges that the insurance company does not cover.

I further understand that if my account is not paid in full within 60 days, a finance charge will be assessed to the unpaid balance in the amount of 1 ½ % per month (18% per annum).

Failed or short-notice cancellations are disruptive to other patients needing to be seen: please help us minimize them. A non-refundable fee will be charged for repeated cancellations.

If a patient comes to a scheduled appointment but decides to not do the scheduled treatment, there will be a \$50.00 charge for the hour.

Patient Name (please print)

Patient Signature

Date

Dr. Amir Sadjadi, D.M.D., P.C.

4950 Barranca Pkwy, #304

Irvine, CA 92604

(949) 861-8441

NO SHOW, CANCELLATION AND LATE ARRIVAL POLICY

In order to be respectful of the Dentists' time and the needs of patients, please be courteous and call promptly if you are unable to show for your scheduled appointment.

If it is necessary to cancel your appointment **we require a call at least 48 hours' advance notice.**

As of 01.01.24 a fee of \$80 will be billed to you if we are not given a 48-hour notice. This is not a billable event to any insurance company as such fee is due from the patient on or before treatment on the next scheduled visit.

Late cancellations: A late cancellation is considered such when a patient fails to cancel their scheduled appointment with a 48-hour advance notice.

Late arrivals: if you are delayed and cannot make an appointment on time please call to advise us of your situation and provide an estimated time of arrival. If you arrive 10 minutes or more to your appointment you will likely be asked to reschedule, unless the Dentist's schedule can still accommodate you.

No show: A "no-show" is considered such when an appointment is missed without calling in advance.

If your case is finished through worker's compensation your adjustor will be notified of your appointment status.

If there are circumstances regarding your missed appointment please contact our office. We understand that there may be issues beyond your control and we wish to be understanding of special circumstances.

I, _____ do hereby authorize Dr. Amir Sadjadi DMD to keep my credit card on file for the purpose of processing my patient fees when applicable. I understand that I can remove this option by informing the front desk staff at any time.

I have read and understood the above explanations.

Patient Name (printed)

Patient Signature

Date

Dr. Amir Sadjadi, D.M.D., P.C.
4950 Barranca Pkwy, #304 - Irvine, CA 92604
(949) 861-8441

REQUESTS FOR PERSONAL RECORDS/INFORMATION

If a patient requests copies of their personal dental records, they must first sign a HIPAA (privacy) release form, which we will provide by email. There will be an administrative/copying charge for this service.

Patient name _____

Date _____

Patient signature _____

Dr. Amir Sadjadi, DMD

4950 Barranca Pkwy

Irvine, CA 92604

PROHIBITED RECORDING & PHOTOGRAPHY

Patient Name: _____

Please note that under California Law patients and visitors may not record, film or disclose any images or sounds of conversation with the doctor or with an office staff member, or take pictures of the office without permission to do so.

Violators may be criminally or civilly liable.

Patient signature

Dr. Amir Sadjadi, D.M.D., P.C.

4950 Barranca Pkwy, #304

Irvine, CA 92604

(949) 861-8441

PATIENT PHOTO AUTHORIZATION

For the purpose of posting "before & after" photos on Instagram and/or our website, please let us know what you authorize:

Patient name _____

(please tick one)

- ☐ I hereby **authorize** Dr. Sadjadi to take photographs of my dental work, **excluding** the rest of my face.
- ☐ I hereby **authorize** Dr. Sadjadi to take photographs of my dental work, **including** the rest of my face.
- ☐ I hereby **do not** authorize Dr. Sadjadi to take photographs of my dental work.

Patient signature

Date
