Sterling Pointe Family Dentistry

General Dentistry Informed Consent

By initialing and signing this form it is understood that ENGLISH is the language that I understand and communicate with.

(initials)_____

A. ANESTHESIA, MEDICATIONS AND DRUGS:
I acknowledge and understand that antibiotics, analgesics (pain killers), and other medications may cause adverse reactions, some of which are, but are not limited to, redness, pain, itching, swelling, dizziness, vomiting, cardiac arrest, miscarriage.

(initials)_____

I acknowledge and understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol and/or other drugs. I have been advised by Dr. Nawabi not to consume alcohol, nor operate any vehicles or hazardous devices while taking medications and or drugs, or until recover fully from their effects. This may include a period of at least 24-48 hours after my release form surgery.

(initials)_____

I acknowledge and understand that occasionally, upon injections of a local anesthetic, I may have prolonged, persistent anesthesia, numbness and or irritations to the area of injection. The numbness may resolve over time or may persist indefinitely.

(initials)_____

I acknowledge and understand that if I elect to use Nitrous Oxide, "Zanax", "Atarax", Chloryl Hydrate, "Ativan" or any other sedative or recreational drugs, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock, cardiac arrest and even death. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 10-12 hours, following my appointment, to observe for possible deleterious side effects, such as obstruction of airway.

(initials)_____

B. PERIODONTICS AND DENTAL HYGIENE (LOSS OF BONE AND TISSUE):
I acknowledge and understand that the long term success of treatment and the status of my oral condition depend on my efforts at proper oral hygiene (that is brushing and flossing) and maintaining regular recall dental visits.

(initials)_____

Periodontitis/Periodontics – I acknowledge and understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that this condition can lead to the loss of my teeth and other complications. The treatment plans that are available have been explained to me which include, but are not limited to, gum surgery, replacements and/or extractions. Although these treatments have a high success rate I do understand that they cannot be guaranteed. I also understand that in some instances the treated teeth may require extractions.

(initials)_____

C. EXTRACTIONS/REMOVAL OF TEETH:
I acknowledge and understand that the purpose of the procedure and surgery is to treat and possibly correct my diseased oral tissues. Dr. Nawabi has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen and deteriorate over time.

The potential risks may include, but are not limited to, the following:

1. Injury to adjacent teeth, fillings, or caps which may require the re-cementation of crowns, replacement of fillings, fabrication of crowns or extraction. Injury to other tissues not within the described surgical areal can also occur.
2. Trismus (limited opening; stiffness of facial and or neck muscles); changes in bite; or jaw joint (TMJ) – TemporoMandibular Joint) difficulty which may require physical therapy and or Surgery.
3. Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage possibly exposing existing/remaining crown margins; tooth looseness; delayed healing; dry-socket and or infection which may require prescriptions or additional treatment such as surgery.

4. Residual root and tooth fragments or bone spicules left behind when complete removal would require additional, extensive surgery or needless surgical complications.
5. Opening of the sinus, a normal cavity (air space) located above the upper teeth that may require additional surgery.
6. . Possible bone and or Jaw fracture(s) that may require wiring or surgical treatment.
7. Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of chin, lip, gums, cheek, teeth and or tongue on the operated side; this may persist for several weeks, months, or in rare cases permanently.

(initials)_____

I give my informed consent for the doctor and staff to perform the treatment/surgery/procedure previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.
If any unforeseen conditions should arise in the course of the surgery/operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize Dr. Nawabi and staff to do whatever he may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

(initials)_____

RESTORABILITY OPTIONS INFORMED CONCENT (if applicable):
I have been advised by Dr. Nawabi and staff that the following tooth/teeth:

_____

_____ may be saved by root canal treatment and/or post-build up and crown(s) or by other restorations (fillings), but I elect to have the above mentioned tooth/teeth extracted, and do not wish to restore the tooth/teeth. The risks, benefits, and alternatives to treatment have been discussed with me and explained to me by my doctor (Dr. Nawabi), and I consent to the extraction of the above mentioned tooth/teeth.

(initials)_____

Signature:_____
Patient or Legal Representative

Print Name:_____

Relationship (please circle): Patient Parent Legal Guardian ***Date:***_____

D. **Fillings:**
I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to trauma or decay. I understand that with time fillings need to be replaced due to wear of material, in cases where very little tooth structure remains, or existing tooth structure fractures and detaches from the tooth, there may be a need for me to receive extensive treatment such a root canal treatment, post and build-up, and crowns, which would necessitate a separate charge.

I acknowledge and understand that silver amalgam (if used to restore my teeth) is an acceptable procedure according to the American Dental Association guidelines and, as such, is a treatment modality that is used by my doctor (Dr. Nawabi). The advantages and disadvantages of alternate materials have been explained to me.

(initials)_____

E. **ROOT CANAL TREATMENT (ENDODONTICS)**

The reasons why I need a root canal and the method have been discussed with me. Risks, benefits, and alternative to treatment, as well as the consequences of non-treatment have been discussed and explained to me. I acknowledge and

understand that following the root canal I will also need a cap (crown) over my tooth because my tooth will be brittle and will need protection against fractures.

I acknowledge and understand that the risks involve can include, but are not limited to:

1. Discomfort lasting hours to several days (if needed, medication will be prescribed by the doctor).
2. Swelling of the area near the treated tooth and/or gums or facial swelling which may persist for several days or longer.
3. Trismus (jaw opening restriction)
4. During treatment root canal instruments may break which in the judgment of the dentist be left in the treated root canal and/or bone as part of the filling material, or may require surgery for removal and/or referral for further treatment by an endodontist (root canal specialist).
5. Risk of temporary or permanent numbness in the area of treatment.
6. Perforation of root canal with instruments, which may require more surgery or result in premature loss of tooth or extraction.

If a pulpotomy or an (open and medicate) procedure is performed, I acknowledge and understand that this is not a complete root canal and permanent treatment, and I will need to pay for, and finish final root canal therapy. If I do not follow these instructions to finalize the root canal treatment, I expose myself to the possibility of infection and/or tooth loss.

If the root canal treatment fails, the therapy may have to be redone by an endodontist, root-end surgery may be required or the tooth may have to be extracted.

(initials)_____

F. **CAPS (CROWNS AND/OR BRIDGES)**

I realize that it may not be possible for the doctor to obtain the exact color match of natural teeth with artificial teeth, and that sometimes root canal therapy may be necessary, since pulp exposure may occur during tooth preparation for a crown. I also realize that I will need to keep my new crowns and/or bridges clean, just as I do my natural teeth. This can be done by proper oral hygiene, and periodic cleanings. If I do not maintain my oral health, the result may be decay around and/or underneath the margins of the restoration. This will result in further dental treatment.

(initials)_____

G. **PARTIAL AND/OR COMPLETE DENTURES**

As a very important part of successfully and properly maintaining my prosthetic appliance, I must schedule and keep follow-up appointments. Sore spots should be examined by the doctor.

Furthermore, I understand that I may possibly never be able to wear dentures to my liking, which may be due to bone loss or other factors of complications. I also realize that for the dentures to be properly fitted I may require surgery, including, but not limited to implants, bone recontouring, or bone (tori) removal, etc.

I fully understand, through the explanations that have been provided to me by the doctor and/or staff, the problems that may result in the wearing of dentures. These, include, but are not limited to relining, possible breakage, soreness, and/or looseness due to change in tissue.

(initials)_____

H. **CHILD DENTISTRY (PEDODONTICS)**

I am fully aware that the following procedures are accepted in the dental profession and are used by the doctor:

a.) POSITIVE REINFORCEMENT – Use of praise, compliments, token objects or toys, pats and/or hugs to reward desirable behavior of a child.

b.) VOICE CONTROL – Changing tone and/or volume of doctors/staff member(s) voice(s) to gain attention of disruptive child.

c.) PHYSICAL RESTRAINT – Use of a special device, known as a "papoose board" and/or the use of the doctor's and/or assistant's hands or arms to restrain the head, hands, upper body and/or legs of a disruptive child that may be necessary for the safety of that child.

d.) ORAL SEDATION AND/OR NITROUS OXIDE – Oral medications may help the child relax. Nitrous oxide which may be used to sedate the patient, is a mild gas and is mixed with oxygen and is administered through a mask, placed over the child's nose. The parent/guardian of the child must be available to escort them home after the sedation procedure. They must also observe the patients behavior throughout the day and should contact the dental office with any observations of abnormal and/or out of the ordinary reactions and/or concerns they may have regarding the patient. The parent/guardian must also understand that the child should not drink or eat for 4 hours prior to the appointment

I fully understand that the child may accidentally bite their lip causing injury to occur as a possible result of the use of injection(s) to numb the tooth area for dental procedures.

I fully understand that if the pain and/or numbness do not disappear after a period of time, I may need to return to the dental office for further evaluation.

I fully understand that following the nerve treatment of a "baby tooth" the child may need to return to the dental office for evaluation, and possible extraction.

(initials)_____

BY SIGNING THIS CONSENT FORM I ACKNOWLEDGE AND UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF DR. NAWABI AND STAFF WHILE I AM UNDER THEIR CARE, REALIZING THAT ANY LACK OF COOPERATION COULD RESULT IN LESS THAN OPTIMUM RESULTS

I ACKNOWLEDGE AND CERTIFY THAT I HAVE HAD THE OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. THE RISKS, BENEFITS AND ALTERNATIVES TO TREATMENT HAVE BEEN EXPLANED AND DISCUSSED AND I HAVE BEEN ENCOURAGED TO ASK QUESTIONS AND HAVE THOSE QUESTIONS ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT DR. NAWABI AND STAFF PROVIDE DENTAL CARE WITHOUT DISCRIMINATING BASED ON SEX, RELIGION, COLOR, RACE, NATIONAL ORIGIN, SEXUAL ORIENTATION, MENTAL OR PHYSICAL DISABILITY, AGE OR MARITAL STATUS OR ANY OTHER PERSONAL ATTRIBUTES AND WILL DO EVERYTHING IN THEIR POWER TO PROTECT THE PRIVACY OF THEIR PATIENTS.

Signature:_____

Patient or Legal Representative

Print Name:_____

Relationship (please circle): Patient Parent Legal Guardian ***Date:***_____

Dentist: Dr. Nawabi

Witness:_____ Print:_____

Feroz M. Nawabi, DDS
Sterling Pointe Family Dentistry
6000 Fairway Drive, Ste 16 (Unit 111)
Rocklin, CA 95677
916-434-7116

STERLING POINTE DENTAL PRACTICE

DR. NAWABI, D.D.S.

(916) 434-7116 FAX: (916) 434-7078

GET ACQUAINTED QUESTIONNAIRE

IN ORDER FOR US TO BETTER SERVE YOU, PLEASE FILL IN THE FOLLOWING INFORMATION *COMPLETELY*: (COMPLETE BOTH SIDES)

Patient's Name:_____ Age:_____ Date of Birth:_____ M F

Phone#_____ Cell#_____ Social Security#_____ Driver's License#_____

Address:_____ City_____ State_____ E-mail _____

If patient is a minor, give parent's/guardian's name_____

If patient is a full-time college student, fill in school name, City/State_____

Emergency Contact:_____ Ph#( )_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE/OR HOW DID YOU HEAR ABOUT OUR PRACTICE?_____

RESPONSIBLE PARTY INFORMATION

Name:_____ Martial Status:_____

Soc. Sec#_____ Date of Birth:_____ Relationship to patient_____

Residence:_____

Mailing Address If Different from Residence:_____

Employer_____ Occupation_____

Employer Address_____

Spouse's Name_____ Date of Birth_____ Soc. Sec#_____

Employer_____ Occupation_____

Employer Address_____

INSURANCE INFORMATION

Insured's Name_____ Insured's Soc. Sec.#_____

Insured's Date of Birth_____ Insurance Co._____ Group#_____

Authorized to Assign Benefits. Insured Signature_____

Is patient covered by another Insurance Plan? Yes ____ No ____

If yes: Name of person carrying Insurance:_____ Date of Birth_____

Soc Sec#_____ Name of Ins. Co._____ Group#_____

Authorized to Assign Benefits. Insured Signature_____

DENTAL INFORMATION

Do your gums bleed when you brush?	Yes	No	Do you wear a nightguard?	Yes	No
Are your teeth sensitive to heat or cold?	Yes	No	Do you wear a Partial or Full Denture?	Yes	No
Do you grind or clench your teeth?	Yes	No	Do you smoke or chew tobacco?	Yes	No
Do you have any fear of dental work?	Yes	No	Are you having pain or discomfort at this time?	Yes	No

Date of last dental visit_____ What was done at the time?_____

Date of last dental cleaning_____ Have you ever been told that you have gum disease or had gum surgery?_____

Former Dentist Name_____ City_____

How would you describe your current dental problem?_____

How do you feel about the appearance of your teeth?_____

I acknowledge that I have received the Dental Materials Fact Sheet.

Patient's Signature_____ Date_____

MEDICAL INFORMATION

1. Have you been a patient in the hospital during the last two years? YES NO
2. Are you now taking any medication or drugs? YES NO

   If yes, please list ALL:_____
3. A. Have you taken any medication or drugs during the last two years? YES NO

   B. Have you ever taken appetite suppressants – fen-phen (fenfluramine & phentermine) or dexfenfluramine or fenfluramine? YES NO
4. Have you been under the care of a medical doctor during the last two years? YES NO

   Physician's Name_____Ph#_____

   Address_____
5. Are you sensitive or allergic to any medication or anesthetics? YES NO

   If yes, please list:_____
6. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure	Yes	No	Artificial Joints (Hip, Knee, etc.)	Yes	No	Hepatitis	Yes	No
Heart Disease or Attack	Yes	No	Kidney Disease	Yes	No	If yes, which strain?	A	B C
Angina Pectoris	Yes	No	Ulcers	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Diabetes	Yes	No	A.I.D.'s	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
Arteriosclerosis	Yes	No	Osteoporosis	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Anemia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Heart Surgery	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Rheumatic Fever	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Arthritis	Yes	No	Allergies or Hives	Yes	No	Yellow Jaundice	Yes	No
Rheumatism	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Cortisone Medicine	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Drug Addiction	Yes	No	Chemotherapy	Yes	No	Neurological Disorder	Yes	No
Stroke	Yes	No	Developmentally Disabled	Yes	No	Tumors	Yes	No
Allergy to Latex	Yes	No	Allergy to Metal	Yes	No	Cancer	Yes	No
Taking Blood Thinner OR **Aspirin?**	Yes	No				If yes, location?_____		

7. When you walk up stairs, do you ever have to stop due to pain in your chest, shortness of breath, or because you are very tired? YES NO
8. Do your ankles swell during the day? YES NO
9. Have you lost or gained more than ten pounds in the past year? YES NO
10. Do you have or have you had any disease, condition, or problem not listed? YES NO

    If yes, please list:_____

FOR WOMEN ONLY:
Are you Pregnant? YES_____What Month?_____NO_____Are you nursing: YES___NO___Are you taking birth control pills? YES___NO___

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature_____Date_____

CONSENT:
1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½% finance charge (18% APR) may be added to my account, in addition to any collection fee charged.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any change in the information obtained on this form.
6. I authorize the use of my social security number to file my dental claim.

Patient Signature_____Date_____

If Patient is a Child, Signature of Parent or Responsible Party_____Relationship to Patient_____

FOR OFFICE USE: Reviewed By Dr._____Date:_____

	Yes	No
Meds Review: **HISTORY OF TAKING ORAL OR IV BISPHOSPHONATES (FOSAMAX ETC.)**_____	☐	☐
HISTORY OF HEAD & NECK RADIATION TREATMENT FOR HEAD & NECK CANCER_____	☐	☐
HEART ATTACK OR STROKE IN THE LAST 6 MONTHS	☐	☐

STERLING POINTE FAMILY DENTISTRY
FEROZ M. NAWABI D.D.S., INC.
6000 FAIRWAY DR., SUITE 16 (UNIT 111)
ROCKLIN, CA 95677
916-434-7116

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I, [full name], have received a copy of the Sterling Pointe Family Dentistry Notice of Privacy Practices.

_____ [Please Print Name]

_____ [Signature]

_____ [Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's name _____

Relationship to Patient_____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

STERLING POINTE FAMILY DENTISTRY OFFICE POLICIES
Dr. Nawabi, D. D. S.

Our philosophy is to provide the highest quality of patient education and dental care to all of our patients To ensure you begin with a positive experience we have prepared the following information for your review. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT

To keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience you will be provided an estimate for services in advance of your appointments to ensure you opportunity to plan in advance for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want.

_____ Initials

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request you familiarize yourself with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 60 days. Please remember that your insurance is a contract between you, your employer, and the insurance company, therefore, we cannot guarantee coverage. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums.

_____ Initials

PAYMENT OPTIONS

For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. ***Please identify which form of payment is most convenient for you at the time of service.***
Cash/Check____ATM____Visa/MasterCard/Discover____Am Exp____Extended Payment__(Please see below)
Please Note: A $25.00 NSF fee will be charged for all returned checks. Should you desire a monthly payment plan we invite you to complete a simple finance company application. There are no application fees or a down payment and the loan can be interest-free

_____ Initials

PAST DUE BALANCES

If applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 90-days, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. All balanced over 60-days are subject to a $10.00 rebilling fee.

_____ Initials

CANCELLATIONS

If you are unable to keep an appointment that has been reserved for you we request you provide us with a 48-72 hour advance courtesy notice. Early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient therefore filling the time previously reserved for you. We realize emergencies do occur and we will be flexible under those circumstances; however, other missed appointments without the requested-notice may incur a $75 fee.

_____ Initials

CELL PHONES

We ask that cell phones and pagers be turned off at all times while in the treatment area. If being available for an emergency during your reserved appointment please leave our office telephone number so you can be reached. Should an unfortunate emergency arise we would be happy to notify you in the treatment area immediately.

_____ Initials

INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to medical history, telephone numbers, address, employer or insurance information as they occur.

_____ Initials

CAMERA SURVEILLANCE

For the protection and safety of our patients and staff, our office is under 24-hour surveillance. If you have any concerns, please contact the office manager.

_____ Initials

My Signature indicates that I understand the office policies as outlined and any questions I have regarding office policies have been answered.

Signature of responsible Party or Patient

_____ Date

My signature indicates that I have reviewed the office policies with the responsible party and/or patient.

Signature of Staff Member or Doctor

_____ Date

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Authorization for the Release of Medical Records

I, _____ [Patient's Name] hereby authorize the release of any and all information you may have concerning my medical condition, which you have obtained as a result of history, examination, testing, diagnosis, x-rays, treatment, and prognosis.

Any and all information may be released including, but not limited to, medical records, mental health records, drug and/or alcohol abuse, lab test results, x-rays, etc.

This authorization shall remain valid. A signed copy of this authorization is as valid as the original.

_____ _____

Signature Date

If not signed by the patient, please indicate relationship to patient:

- ☐ Power of Attorney / Advance Directive
- ☐ Conservator or Guardian