

Aesthetic Smiles
Maryam M. Motlagh, D.M.D., P.C.
13765 NW Cornell Road, Suite 100
Portland, OR 97229
503-643-9855 503-626-7154 (fax)
www.aesmiles.com

Dear Patient,

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable prices, and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

Your appointment, will take approximately 60-minutes. To facilitate being seen just as soon as possible at the time of your appointment, we would be grateful if you would complete the enclosed Patient Information Forms prior your arrival and **bring them with you to your appointment.**

Your appointment will consist of the following:

- Diagnostic Radiographs
- Gum disease evaluation
- Tooth decay assessment
- TMJ Occlusion Evaluation
- Head and Neck Cancer Screening
- Blood pressure check
- Review of Medical and Dental History

I will work with you to plan your treatment and identify any needed follow-up appointments, **including cleanings.**

If you are unable to make the appointment you have scheduled with us, please notify us at least 24 hours in advance. We would be glad to reschedule the appointment at a more convenient time. In the meantime, we look forward to meeting you and serving your needs.

Thanks again for choosing our dental practice.

Sincerely,

Maryam M. Motlagh D.M.D., PC

P.S. Please remember to bring your insurance ID cards with you to your appointment.

WELCOME

Patient's Name _____
Last First Initial Date of birth

COMMENTS

- 1 Purpose of initial visit _____
- 2 Are you aware of a problem? _____
- 3 How long since your last dental visit? _____
- 4 What was done at that time? _____
- 5 Previous dentist's name _____
Address: _____ Ph # _____
- 6 When was the last time your teeth were cleaned? _____
CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER
PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION
- 7 Have you made regular visits?..... Yes or No
- 8 Were dental x-rays taken?..... Yes or No
- 9 Have you lost any teeth or have any teeth been removed?..... Yes or No
Why? _____
- 10 Have they been replaced?..... Yes or No
- 11 How have they been replaced?
a. Fixed Bridge _____ Age _____
b. Removable Bridge/Partial Denture _____ Age _____
c. Denture _____ Age _____
d. Implant _____ Age _____
- 12 Are you unhappy with the replacement?..... Yes or No
If yes, explain _____
- 13 Would you like to know about permanent replacements?..... Yes or No
- 14 Have you ever had any problems or complications with previous dental treatment?..... Yes or No
If yes, explain _____
- 15 Do you grind or clench your teeth?..... Yes or No
- 16 Does your jaw click or pop?..... Yes or No
- 17 Have you experienced any pain or soreness in the muscles of your face
or around your ear?..... Yes or No
- 18 Do you have frequent headaches, neckaches or shoulder aches?..... Yes or No
- 19 Does food get caught in your teeth?..... Yes or No
- 20 Are your teeth sensitive to: Hot? Cold? Sweets? Pressure?
- 21 Do your gums bleed or hurt?..... Yes or No
When? _____
- 22 How often do you brush your teeth? _____ When? _____
- 23 Do you use dental floss?..... Yes or No
How often? _____
- 24 Are any of your teeth loose, tipped, shifted or chipped?..... Yes or No
- 25 Are you unhappy with the appearance of your teeth?..... Yes or No
- 26 How do you feel about your teeth in general? _____
- 27 Do you feel your breath is offensive at times?..... Yes or No
- 28 Have you ever had gum treatment or surgery?..... Yes or No
What? _____
Where? _____
When? _____
- 29 Have you ever had any orthodontic work? _____
- 30 Have you had any unpleasant dental experiences or is there anything about dentistry that you
strongly dislike? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN SIGNATURE _____ DATE _____

DENTIST SIGNATURE _____ DATE _____

WELCOME

Patient's Name _____
Last First Initial Date of birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER

PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

COMMENTS

- 1 Physician's Name _____
Address _____
Tel: () _____
- 2 Are you under a physician's care?..... Yes or No
Since when _____ Why _____
- 3 When was your last complete physical exam? _____
- 4 Are you taking any medication or substances?..... Yes or No
(If yes, please list medications in comments section or on the back of this form..... Yes or No
- 5 Do you routinely take health related substances? (Vitamin, herbal supplements, natural product) Yes or No
- 6 Are you allergic to any medications or substances? (please list)..... Yes or No
- 7 Do you have any other allergies or hives?..... Yes or No
- 8 Do you have any problems with penicillin, antibiotics, anesthetics or other medications?... Yes or No
- 9 Are you sensitive to any metals or latex?..... Yes or No
- 10 Are you pregnant or suspect you may be? Due Date _____ Yes or No
- 11 Do you use any birth control medications?..... Yes or No
- 12 Have you ever been treated for or been told you might have heart disease?..... Yes or No
- 13 Do you have a pacemaker or an artificial heart valve implant?..... Yes or No
- 14 Have you ever had rheumatic fever?..... Yes or No
- 15 Are you aware of any heart murmurs?..... Yes or No
- 16 Do have high or low blood pressure? (Please circle) Yes or No
- 17 Have you ever had a serious illness or major surgery?..... Yes or No
If yes, please explain _____ Yes or No
- 18 Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?..... Yes or No
- 19 Do you have inflammatory diseases, such as arthritis or rheumatism?..... Yes or No
- 20 Do you have any artificial joints prosthesis?..... Yes or No
- 21 Do you have any blood disorders, such as anemia, leukemia, etc?..... Yes or No
- 22 Have you ever bleed excessively after being cut or injured?..... Yes or No
- 23 Do you have any stomach problems?..... Yes or No
- 24 Do you have any kidney problems?..... Yes or No
- 25 Do you have any liver problems?..... Yes or No
- 26 Are you diabetic?..... Yes or No
- 27 Do you have fainting or dizzy spells?..... Yes or No
- 28 Do you have asthma?..... Yes or No
- 29 Do you have epliepsy or seizure disorders?..... Yes or No
- 30 Do you have venereal disease?..... Yes or No
- 31 Have you tested HIV positive?..... Yes or No
- 32 Do you have AIDS?..... Yes or No
- 33 Have you had or do you test positive for hepatitis?..... Yes or No
- 34 Do you or have you had I.B.?..... Yes or No
- 35 Do you smoke, chew, use snuff or any other form of tobacco?..... Yes or No
- 36 Do you consume alcoholic beverages?..... Yes or No
- 37 Do you habitually use controlled substances?..... Yes or No
- 38 Have you had psychiatric treatment?..... Yes or No
- 39 Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine, (redux), or other weight loss products?..... Yes or No
- 40 Do you have any disease condition, or problem not listed? If so, explain _____
_____ Yes or No
- 41 Is there anything else we should know about your health that we have not covered in this form?

- 42 Would you like to speak to the Doctor privately about any problem?..... Yes or No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN SIGNATURE _____

DATE _____

DENTIST SIGNATURE _____

DATE _____

MARYAM M. MOTLAGH, D.M.D., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

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
 - Communication barriers prohibited obtaining acknowledgment
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
-
-
-

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/1/2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

