JACQUELINE YOUNESI
DENTISTRY

Jacqueline Younesi Dentistry
2121 E. Coast Highway #230
Corona Del Mar, CA 92625
949-409-9895
office@jyounesidentistry.com

NEW PATIENT INFORMATION

PATIENT INFORMATION

_____ _____
FIRST AND LAST NAME DATE

_____
PREFERS TO GO BY

ADDRESS CITY STATE ZIP

_____ _____
CELL PHONE HOME PHONE

_____
EMAIL ADDRESS

_____ _____ _____
DATE OF BIRTH AGE MALE FEMALE OTHER

_____ _____ _____ _____ _____
MARRIED SINGLE DIVORCED WIDOWED SOCIAL SECURITY NUMBER

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

_____ _____
NAME RELATIONSHIP

_____
YOU WERE REFERRED TO US BY

EMERGENCY CONTACT

_____ _____ _____
NAME PHONE NUMBER RELATIONSHIP

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PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

NAME _____ RELATIONSHIP TO PATIENT _____ PHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DENTAL INSURANCE INFORMATION:

PRIMARY CARRIER

INSURANCE COMPANY _____

GROUP NUMBER _____

EMPLOYER NAME _____ INSURED'S NAME _____

PATIENT DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

INSURED'S ID NUMBER _____ INSURED'S SOCIAL SECURITY NUMBER _____

SECONDARY CARRIER

INSURANCE COMPANY _____

GROUP NUMBER _____

EMPLOYER NAME _____ INSURED'S NAME _____

PATIENT DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____

INSURED'S ID NUMBER _____ INSURED'S SOCIAL SECURITY NUMBER _____

JACQUELINE YOUNESI
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HEALTH HISTORY FORM
Jacqueline Younesi Dentistry

Patient Name: _____ Date of Birth: _____

Physician's Name: _____ **Physicians Phone Number:** _____

Are you taking any medications? ☐ Yes (please fill out the names and amounts below, including over-the-counter)
☐ No

_____

_____

Have you had any medical care within the past two years? ☐ Yes ☐ No

Have you been a patient in the hospital in the last five years? ☐ Yes ☐ No

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other Bisphosphonates?

☐ Yes ☐ No If yes, please list: _____

Have you ever been told you need to premedicate prior to dental care?
☐ Yes ☐ No

Do you smoke, vape or use tobacco/marijuana products?
☐ Yes ☐ No

Are you allergic/have you had an adverse reaction to any of the following?

Aspirin:	☐ Yes	☐ No	Latex:	☐ Yes	☐ No
Codeine:	☐ Yes	☐ No	Dental Anesthetics:	☐ Yes	☐ No Which ones? _____
Sulfa Drugs:	☐ Yes	☐ No	Other	☐ Yes	☐ No _____
Penicillin:	☐ Yes	☐ No			

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

Heart (Surgery, Disease, Attack):	☐ Yes	☐ No	Rheumatic Fever:	☐ Yes	☐ No
Chest Pain:	☐ Yes	☐ No	Arthritis/Rheumatism:	☐ Yes	☐ No
Congenital Heart Disease:	☐ Yes	☐ No	Cortisone Medicine:	☐ Yes	☐ No
Heart Murmur:	☐ Yes	☐ No	Swollen Ankles:	☐ Yes	☐ No
High/Low Blood Pressure:	☐ Yes	☐ No	Stroke:	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Diet (Special/Restricted):	☐ Yes	☐ No
Artificial Heart Valve/Pacemaker:	☐ Yes	☐ No	Artificial Joints:	☐ Yes	☐ No
High Cholesterol:	☐ Yes	☐ No	Chemotherapy:	☐ Yes	☐ No
Ulcers:	☐ Yes	☐ No	Tumors:	☐ Yes	☐ No
Diabetes:	☐ Yes	☐ No	Hepatitis A/B/C (circle):	☐ Yes	☐ No
Thyroid Problems:	☐ Yes	☐ No	Venereal Disease:	☐ Yes	☐ No
Glaucoma:	☐ Yes	☐ No	A.I.D.S/H.I.V Positive:	☐ Yes	☐ No
Contact Lenses:	☐ Yes	☐ No	Cold Sores/Fever Blisters:	☐ Yes	☐ No
Emphysema:	☐ Yes	☐ No	Blood Transfusion:	☐ Yes	☐ No
Chronic Cough:	☐ Yes	☐ No	Hemophilia:	☐ Yes	☐ No
Tuberculosis:	☐ Yes	☐ No	Sickle Cell Disease:	☐ Yes	☐ No
Asthma:	☐ Yes	☐ No	Bruise Easily:	☐ Yes	☐ No
Hay Fever/Allergy/Hives:	☐ Yes	☐ No	Liver Disease/Yellow Jaundice:	☐ Yes	☐ No
Latex Sensitivity:	☐ Yes	☐ No	Neurological Disorders:	☐ Yes	☐ No
Sinus Trouble:	☐ Yes	☐ No	Epilepsy or Seizures:	☐ Yes	☐ No
Nervous/Anxious:	☐ Yes	☐ No	Fainting or Dizzy Spells:	☐ Yes	☐ No
Psychiatric/Psychological Care:	☐ Yes	☐ No	Kidney Trouble:	☐ Yes	☐ No
Cancer:	☐ Yes	☐ No	Other :	☐ Yes	☐ No
			Please describe: _____		

Women:
Are you pregnant or think you could be pregnant? ☐ Yes ☐ No Are you Nursing? ☐ Yes ☐ No Do you use birth control? ☐ Yes ☐ No

_____ _____
Signature of Patient (Parent/Guardian if a minor) Date

JACQUELINE YOUNESI
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DENTAL HISTORY FORM
Jacqueline Younesi Dentistry

Patient Name: _____ Date of Birth: _____

What is the reason for today's visit?

_____

_____

Date of Last Dental Visit: _____ Date of Last Dental Cleaning: _____ Date of Last Full Mouth X-rays: _____

What was done at your last dental visit? _____

Previous Dentists Name: _____ Phone Number: _____

Address: _____

How often do you have dental examinations? _____

How often do you brush your teeth?_____ How often do you floss? _____

Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No ☐ Not Sure

What other dental aids do you use? (toothpick, waterpick, tongue scraper, etc.)

_____

Do you have any dental problems currently? ☐ Yes ☐ No
If yes, please describe: _____
_____

Are any of your teeth sensitive to:

Hot or cold?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No
Biting or Chewing?	☐ Yes	☐ No
Have you noticed any mouth odors or bad taste?	☐ Yes	☐ No
Do you get cold sores, blisters, or other lesions?	☐ Yes	☐ No
Do your gums bleed or hurt?	☐ Yes	☐ No
Do your parents have gum disease or tooth loss?	☐ Yes	☐ No
Have you noticed any loose teeth or bite changes?	☐ Yes	☐ No
Does food get caught in between your teeth?	☐ Yes	☐ No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	☐ Yes	☐ No
Bite your lips or cheeks regularly?	☐ Yes	☐ No
Hold foreign objects with your teeth?	☐ Yes	☐ No
Mouth breathe while awake or asleep?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No
Snore or have any other sleeping disorders?	☐ Yes	☐ No
Smoke/chew tobacco or other tobacco products?	☐ Yes	☐ No

Have you ever had:

Orthodontic treatment?	☐ Yes	☐ No
Oral Surgery?	☐ Yes	☐ No
Periodontal treatment?	☐ Yes	☐ No
A bite plate or mouth guard?	☐ Yes	☐ No
A serious injury to the mouth or head?	☐ Yes	☐ No

Please describe, including cause: _____
_____

Have you experienced?

Clicking or popping of the jaw?	☐ Yes	☐ No
Pain? (joint, ear, side of face)	☐ Yes	☐ No
Difficulty in opening or closing the mouth?	☐ Yes	☐ No
Headaches, neck aches or shoulder aches?	☐ Yes	☐ No
Sore muscles? (neck, shoulders)	☐ Yes	☐ No

Are you satisfied with your teeth's appearance?

Would you like to replace your silver fillings?	☐ Yes	☐ No
Would you like to keep all of your teeth?	☐ Yes	☐ No

Do you feel nervous about having dental treatment? ☐ Yes ☐ No
Please describe: _____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No
Please describe: _____

_____ _____
Signature of Patient (Parent/Guardian if a minor) Date

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OFFICE TREATMENT/FINANCIAL POLICY AGREEMENT

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but are not limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I agree to the use of anesthetics, sedatives and other medication as necessary. I also understand that the use of anesthesia carries with it significant risks that have been explained to me. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

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FINANCIAL RESPONSIBILITY:

I understand and acknowledge that I am fully and completely responsible for the payment of all services rendered on my behalf or on behalf of my dependents. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me and/or my dependents. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me and/or my dependents. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist, I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto. You will be asked to pay the full amount of the charges the day the service is rendered**.** We will estimate as closely as possible, your coverage, but until you actually receive the reimbursement from the insurance company, it is just an **estimate**.

I understand that **payment is due at the time of treatment** unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% charge (18% APR) may be added to my account. Balances beyond 90 days will result in the account being turned over to a collections agency, resulting in a mark on credit until the balance is paid off.

I consent to the dentists use and disclosure of my health information to my insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom any unpaid account balance has been assigned to referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline).

_____ _____

Patient/Guardian Signature Date

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CANCELLATION POLICY AGREEMENT

Here at Jacqueline Younesi Dentistry, we strive to provide the best care possible for our patients. To do so, office hours are by appointment only and reserved appointment times are for you and you alone. To stay as consistent as possible with this, we have in place an Appointment Cancelation Policy.

We ask our patients to understand that when an appointment that has been scheduled is missed, that time slot cannot be used to treat another patient. Thus we require a 48 hour notice for rescheduling and/or cancelling appointments.

If an appointment is missed without contacting our office in that time frame, it is deemed as a missed appointment and a $75 cancellation fee will be charged to your account. Also, an arrival to an appointment late by 20 minutes or more without prior notification will be considered a missed appointment and the same fee will be assessed.

We understand that emergencies do happen and things may come up. These instances will be evaluated on a case by case basis.

We thank you for understanding and acknowledging this policy. Please let us know if you have any questions.

I have read and understand the Appointment Cancellation Policy and agree to abide by its terms.
I am also aware that the terms of this policy may be amended by the practice in the future.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the member(s) and relationship to the patient:

_____

_____

This consent was signed by:

_____ _____ _____

Patient Name (Print) Signature Date

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ELECTRONIC COMMUNICATION CONSENT

Due to the changing world of healthcare and technology, Jacqueline Younesi Dentistry now has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.

Jacqueline Younesi Dentistry believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you.

Until I tell you in writing to stop, I authorize Jacqueline Younesi Dentistry to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Jacqueline Younesi Dentistry health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.

- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.

- If I don't sign this form, Jacqueline Younesi Dentistry may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.

- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re-disclosed and no longer protected by privacy law.

-I agree to inform the practice if my email address or cell phone number changes. I understand and acknowledge that I can cancel this consent at any time.

-I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Jacqueline Younesi Dentistry already sent before receiving my written instructions to stop.

_____ _____

Patient/Guardian Signature Date

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SOCIAL MEDIA RELEASE CONSENT

I, _____ , hereby agree and give my permission for Jacqueline Younesi Dentistry and Dr. Jacqueline Younesi to use pictures of my smile, both before and after, in the capacity of case presentation.

I understand that my photos, both before and after, may be used in:

- Social media posts (Instagram and Facebook), company website gallery, as well as in-office photography, hanging on the wall in the waiting room, in operatories, and in a compilation book for case presentation.

I understand that these photos will not be used for any other commercial purposes without my written consent.

By designating the appropriate box below, I grant my permission in the following manner:

___ I authorize and permit Jacqueline Younesi Dentistry and Dr. Jacqueline Younesi to use my smile photos, full-face photos, first name and a brief story about my smile in all forms of media release as outlined above.

___ I authorize and permit Jacqueline Younesi Dentistry and Dr. Jacqueline Younesi to use my smile photos, full-face photos, and first name but no brief story about my smile in all forms of media release as outlined above

___ I authorize and permit Jacqueline Younesi Dentistry and Dr. Jacqueline Younesi to use only my smile photos, but **NOT** my first name in all forms of media release as outlined above

___ I decline to participate in any/all social media

_____ _____
Patient, Legal Guardian or Authorized Representative (Print) Date

_____
Signature of Patient, Legal Guardian or Authorized Representative