Smart Smile
FAMILY, COSMETIC AND ORTHODONTIC DENTIST

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smartsmileoc.com

The safety of our employees, patients, and community remain Smart Smile Dental's overriding priority. As the coronavirus disease 2019 (COVID-19) outbreak continues to evolve and spreads globally, Smart Smile Dental is monitoring the situation closely and will periodically update company guidance based on current recommendations from the Centers for Disease Control and Prevention and the California Dental Association.

ARE YOU AT RISK?
1. Have you traveled out-of-state or internationally within the last month? ☐ *YES* ☐ *NO*
2. Have you experienced any cold or flu-like symptoms such as: fever, coughing, or shortness of breath within the last 14 days? ☐ *YES* ☐ *NO*
3. Have you come into contact with someone confirmed to have COVID-19? ☐ *YES* ☐ *NO*
4. Have you been in close contact with anyone who has traveled within the last 30 days internationally? ☐ *YES* ☐ *NO*
5. Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? ☐ *YES* ☐ *NO*
6. Have you experienced recent loss of taste or smell? ☐ *YES* ☐ *NO*

Print Name:_____

Signature_____ Date: _____

SMART SMILE DENTAL

Dr. Lori Bagai DDS Inc

FINANCIAL OPTIONS

Our commitment is to provide quality comprehensive dental care to the entire family through exceptional service and utilization of advanced technology.

METHODS OF PAYMENT

Cash, check or credit card, Dental Insurance, CareCredit

DENTAL INSURANCE

1. We are pleased that you have dental insurance and our office will assist you in obtaining the maximum benefit specified in your contract. **Your insurance is between you, your employer and the insurance company.** You are responsible for all payments due.
2. As a courtesy to you we will file your insurance and accept assignment of benefits if you have signed the insurance payment authorization. We will wait 30 days for insurance payment, after 30 days you are responsible for the payment that is expected from the insurance. Once we have received the Explanation of Benefit from the insurance, adjustments will be made and your account reconciled.
3. **We ask that your estimated co-payment and deductible be paid at the time of scheduling the appointment.**
4. Some insurance companies deny coverage because in their opinion the treatment was not needed. We use our clinical judgement and training in diagnosing according to standard of care. **If services are rendered and insurance denies payment for any reason, payment is due in full as soon as the claim processes.**

RELATED INFORMATION

1. In the event that the account is not paid and we refer the account to collection, you will be responsible for all of the fees incurred in the collection of your bill (i.e. attorney fees, court costs and collection agency fees).
2. Your appointment time and chair has been reserved exclusively for you. Any change in your appointment affects many patients, 48 hours advanced notice is needed to avoid a $75 charge. If you have a 2 hour or longer appointment, the fee will be $150.
   - **CANCELLATIONS**: To avoid a cancellation fee you must cancel the appointment 48 hours in advance. 48 hours is defined as two business days. Messages left over the weekend are not considered sufficient notice. *NO Email/Text/Online CANCELLATIONS*
3. Promotional treatment costs are final an refunds are not permitted.

Who may we thank for referring you?

☐ Online Word Search _____ ☐ Insurance _____ ☐ Friend/Patient_____

I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from the services rendered. I agree to be responsible for any charges not paid by my dental plan.

Patients NAME: _____

SIGNATURE: _____ DATE: _____

Health History Form

ADA
American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last, First, Middle) | Home Phone: *Include area code* ( ) - | Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink in a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: _____ Phone: _____

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Patient Name: _____
Patient DOB: _____
Date: _____

Epworth Sleepiness Scale Questionnaire

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

1. Have you ever been told you stop breathing while asleep?	Y / N	8
2. Have you ever fallen asleep or nodded off while driving?	Y / N	6
3. Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y / N	6
4. Do you feel excessively sleep during the day?	Y / N	4
5. Do you snore, or have you ever been told that you snore?	Y / N	4
6. Do you have trouble falling asleep?	Y / N	4
7. Do you have trouble staying asleep once you fall asleep?	Y / N	4
8. Do you kick or jerk your legs while sleeping?	Y / N	3
9. Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y / N	3
10. Do you wake up with headaches during the night or in the morning?	Y / N	3
11. Have you had weight gain and found it difficult to lose?	Y / N	2
12. Have you taken medication for, or been diagnosed with high blood pressure?	Y / N	2
Total Score		

For Doctor/Staff Use Only

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Visual Indications

- ☐ Enlarged/Scalloped Tongue
- ☐ Retruded Lower Jaw
- ☐ High Arching Hard Palate
- ☐ Bruxism
- ☐ Gastroesophageal Reflux
- ☐ Enlarged Tonsils
- ☐ Mouth Breather

Have you ever been diagnosed with a sleep disorder? Yes or No
Are you currently using a CPAP machine? Yes or No (if yes) Do you use it every night? Yes or No

Notes:

ViziLitePRO

ORAL LESION SCREENING SYSTEM

Adjunctive Oral Abnormalities Screening Form

Complete each time the exam is offered and place in the patient's file

Our practice continually strives to provide important enhancements in oral healthcare for our patients. We are concerned about oral abnormalities and their relationship with serious diseases such as oral cancer. For this reason, we offer screenings to every patient for early detection.

Oral cancer is one of the deadliest diseases we encounter, and research shows that the late detection of oral cancer is the primary reason that mortality rates are high.1 As is the case with most other cancers, age is a primary risk factor for oral cancer. Tobacco use and chronic alcohol consumption are also major risk factors. We find that using ViziLite PRO — along with a visual examination — improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of abnormalities can minimize or eliminate the harmful and potentially disfiguring effects of serious oral diseases such as cancer, and possibly save your life. A painless exam gives us a better chance of finding any oral abnormalities you may have at an early stage. In our practice, the exam will be offered to you annually.

Dental insurance may or may not cover the exam. However, our office is happy to verify your coverage for you. We will also provide you with a medical insurance form that you may use to file this procedure with your medical insurance provider. The fee for this exam is $ 94.

_____ Yes. I authorize the my dental professional to perform the ViziLite PRO screening along with the standard oral examination. I accept financial responsibility for this exam.

_____ No. I would prefer not to have an oral abnormality screening exam at this time.

Print name: _____

Signature: _____ Date: _____

Oral cancer risks include:

- Tobacco use
- Chronic alcohol consumption
- Oral HPV 16/18 infection

1-800-4DENMAT
(1-800-433-6628)
www.denmat.com

DenMat®

1 oralcancerfoundation.org/facts

SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO:

1. PROCESS ALL INSURANCE CLAIMS;
2. ENSURE PAYMENT FOR SERVICES PROVIDED
3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS
4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical and surgical benefits, including major medical benefits to which I am entitled, to **Dr. Lori Bagai / Smart Smile Dental**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature: _____

Patient Full Name (printed): _____

Parent Signature (if minor): _____

Witness: _____

Date Signed: _____

COMPARISONS OF DIRECT/INDIRECT RESTORATIVE DENTAL MATERIALS ACKNOWLEDGEMENT AND HIPPA ACKNOWLEDGEMENT

COMPARISONS OF DIRECT/INDIRECT RESTORATIVE DENTAL MATERIALS ACKNOWLEDGEMENT

I have received the Notice of Comparisons of Direct/Indirect Restorative Dental Materials, and I have been provided an opportunity to review them.

Name: _____ Birthdate: _____

Signature: _____ Date: _____

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.
SIGN BELOW THAT YOU HAVE RECEIVED THIS INFORMATION.

Name: _____

Signature: _____ Date: _____

Smart Smile
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Dr. Lori Bagai, DDS
1110 E Chapman Ave, Suite 105, Orange, CA 92866
Email: staff@smartsmileoc.com
Tel: (714) 744-1242
smartsmileoc.com

Name: _____

What issue(s) or area(s) about your oral health and smile would you like to address?

_____
_____

How urgent are these for you on a scale of 1-10, with 10 being the most urgent?

_____
_____

Your oral health is important to us, and we want to ensure you have a plan for obtaining optimum oral wellness. What is your financial plan for this treatment? Would you like information regarding financing options you may qualify for?

_____
_____

When it comes to your medical and financial decisions, is there anyone else that will need to be included in the overall discussion of your treatment plan and cost before moving forward with your treatment? If so, please let us know so we can make special accommodations for you.

_____
_____

PHARMACY LOCATION

Patient Name: _____ Date: _____

Pharmacy Name: _____

Phone Number: _____

Street Address: _____

City: _____

Zip Code: _____

Cross street: _____