Welcome…

Thank you for selecting ORA Dentistry Spa! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please complete these forms completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Dr. Sam D. Saleh, DDS. BDS. 421 North Rodeo Drive, Penthouse Level, Beverly Hills, CA 90210 (310) 273-0848

Patient Information (CONFIDENTIAL)

Name _____ Date _____

Gender _____ Male _____ Female Birth date _____ Social Security # _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced

If the patient is a minor, the responsible party must complete the next section.

Mailing Address _____

Phone Numbers Home _____ Cell _____

Work _____ Fax _____ Other _____

Email Address _____

Employer _____ Address _____

Whom may we thank for referring you? _____

Person to Contact in Case of Emergency _____ Phone Number _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Gender _____ Male _____ Female Birth date _____ Social Security # _____

Mailing Address _____

Phone Numbers Home _____ Cell _____ Other _____

Email Address _____ Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is due in full at each appointment.

☐ Cash Credit Card ☐ AMEX ☐ VISA ☐ MasterCard Financing ☐ Care Credit ☐ Chase Health Finance

☐ I wish to discuss the office's payment policy *Sorry, we do not accept personal checks as a payment.*

Patient Dental History

Previous Dentist _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain from any of your teeth?	☐	☐
If yes, please explain _____		
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing		
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement? _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐
If no, please explain _____		
17. Are you happy with the color of your teeth?	☐	☐
18. Have you ever had teeth whitening?	☐	☐
If yes, which process did you use and when was the last time you had it? _____		
19. Are you happy with the position of your teeth?	☐	☐

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Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication (s) including non-prescription medicine?	☐	☐
If yes, what medication (s) are you taking? _____		
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐

7. Are you allergic to or have you had any reactions to the following?	Yes	No
Aloe Vera	☐	☐
Ibuprofen	☐	☐
Latex Rubber	☐	☐
Local Anesthetics (e.g. Novocain)	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Other (please list) _____	☐	☐
8. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

6. Do you have any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Hepatitis / Jaundice	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Diabetes	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Kidney Diseases	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Respiratory Problems	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles / Ulcers	☐	☐	Other _____	☐	☐

Appointment Cancellation Policy

In order to provide the finest dental treatment, we must utilize our resources efficiently and effectively. For your appointment, we allot a specific amount of the doctor's time just for you. As a courtesy, we ask that you give us notice at least 24 hours in advance for appointment changes or cancellations. This will allow enough time to schedule another patient in your place, as we always have patients waiting for openings.

Should you need to reschedule or cancel your appointment without proper notice, you will incur a **$75 cancellation/rescheduling fee**. If a patient is at least 30-45 minutes late to his or her appointment, he or she may be subject to the fee. ORA Dentistry Spa must be notified or we're going to assume the appointment has been cancelled after 30 minutes of no notice and they will be charged a fee. This fee will be charged to your credit card that will be kept in your patient file for this reason only. We thank you in advance for the courtesy of providing 24 hours notice for appointment changes or cancellations.

Please complete the following information:

Credit card info:
Name on Card _____
Type _____ Number _____
Expiration Date _____ Security Code _____
Billing Address _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. ***I understand that my dental insurance carrier may pay less than the actual bill for services.*** *I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

X_____ _____

Signature of patient (or parent/guardian if minor) Date

Doctor's or Staff Comments _____