



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

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Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No		Yes	No	
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>		7. Are you allergic to or have you had any reactions to the following?			<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>		Aloe Vera		<input type="checkbox"/>	<input type="checkbox"/>		
If yes, please explain _____				Ibuprofen		<input type="checkbox"/>	<input type="checkbox"/>		
3. Are you taking any medication (s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>		Latex Rubber		<input type="checkbox"/>	<input type="checkbox"/>		
If yes, what medication (s) are you taking? _____				Local Anesthetics (e.g. Novocain)		<input type="checkbox"/>	<input type="checkbox"/>		
4. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>		Any Metals (e.g. nickel, mercury, etc.)		<input type="checkbox"/>	<input type="checkbox"/>		
5. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>		Penicillin or any other Antibiotics		<input type="checkbox"/>	<input type="checkbox"/>		
6. Do you have any of the following?				Other (please list) _____		<input type="checkbox"/>	<input type="checkbox"/>		
	Yes	No		8. Women Only:					
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		a) Are you pregnant or think you may be pregnant?		<input type="checkbox"/>	<input type="checkbox"/>		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		b) Are you nursing?		<input type="checkbox"/>	<input type="checkbox"/>		
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>		c) Are you taking oral contraceptives?		<input type="checkbox"/>	<input type="checkbox"/>		
Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>							
Fainting / Seizures	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	Yes	No	Yes	No	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>		Angina	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>		Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
				Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
				Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
				Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
				Stomach Troubles / Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
							Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
							Other _____	<input type="checkbox"/>	<input type="checkbox"/>

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 _____ _____ _____
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