FARZAD SHAYGAN D.D.S., M.S. INC.
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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that the communication of the PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

( ) Home telephone:________________
- ( ) O.K. to leave message with detailed information
- ( ) Leave message with call-back number only

( ) Work telephone: ___________________
- ( ) O.K to leave message with detailed information
- ( ) Leave message with call-back number only

( ) Written Communication:
- ( ) O.K to mail info. to my home address
- ( ) O.K to mail info. to work/office address
- ( ) O.K to fax info. To this number ____________

( ) Other ______________________________
Cell or E-mail

______________________________________ Patient or Guardian's Signature

______________________________ Date

______________________________________ Print Patient's Name

______________________________ Birthdate

The Privacy rule generally requires healthcare providers to take reasonable steps to limit the uses of disclosure and requests to PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.
Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
Note: Use and Disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to	Purposed Of Disclosure	By Whom Disclosed	(1)

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date ___________________

Patient ____

Address ____

____
City State Zip

Sex: ☐ M ☐ F Age __________ Birthdate ______________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If patient is a child give parent/guardian (s) information below :

Patient/Guardian SS # ______________________________

Calif. Driver's Lic # : ______________________________

Employer ____

Occupation ____

Employer Address ______________________________

Spouse's Name ____

Birthdate ________________SS# ________________________

Occupation ____

Spouse's Employer ______________________________

2 DENTAL INSURANCE

Who is responsible for this account ? ________________________

Relationship to Patient __________________________________

Ins. Co. ___________________________ Grp # __________

Is patient covered by additional Insurance ( ) YES ( ) NO

Only fill out if other coverage applies:

Subscriber's Name ______________________________________

Birthdate ____________________ SS # ____________________

Relationship to Patient __________________________________

Insurance Co. _________________ Grp # _________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (for my dependent) have insurance coverage with __________________________ and assign directly to **Dr. Farzad Shaygan,** all insurance benefits, if any, otherwise payable to me for services rendered, I u nderstand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to r elease all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submi ssions.

____

Responsible Party Signature

____________________________________ ________________

3 PHONE NUMBERS

Home: ____________________ Work: __________________ Cell: ___________________ Email: ______________________

Out of courtesy to our patient (s) we do call and confirm the day before your scheduled appointment please give us the best place and time to reach you ? ____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ____Relationship ____________________________________

Home Phone ______________________________________ Work ______________________ Ext _______ Cell ______________________

4 Dental History

Reason for today's visit ________________

____

Former Dentist ________________________

City/State ____________________________

Date of last dental visit ________________

Date of last dental X -rays _______________

Place a mark on "Yes" or "No" to indicate If you have had any of the following:

Bad breath	( ) Yes	( ) No
Bleeding gums	( ) Yes	( ) No
Burning sensation on tongue	( ) Yes	( ) No
Chew on one side of mouth	( ) Yes	( ) No
Cigarette, pipe, or cigar smoking	( ) Yes	( ) No
Dry mouth	( ) Yes	( ) No
Clicking or popping jaw	( ) Yes	( ) No
Fingernail biting	( ) Yes	( ) No
Food collection between the teeth	( ) Yes	( ) No
Grinding teeth	( ) Yes	( ) No
Gums swollen or tender	( ) Yes	( ) No
Jaw pain or tiredness	( ) Yes	( ) No
Loose teeth or broken fillings	( ) Yes	( ) No
Mouth breathing	( ) Yes	( ) No
Mouth pain (brushing)	( ) Yes	( ) No
Orthodontic treatment	( ) Yes	( ) No
Pain around ear	( ) Yes	( ) No
Periodontal treatment	( ) Yes	( ) No
Sensitivity to cold	( ) Yes	( ) No
Sensitivity to heat	( ) Yes	( ) No
Sensitivity to sweets	( ) Yes	( ) No
Sensitivity when biting	( ) Yes	( ) No
Sores or growths in your mouth	( ) Yes	( ) No

HEALTH QUESTIONAIRE

Patient Name ____

Home Address: ____

_______________ Daytime Phone ______________________

Email address: ____

Employer Name: ____

Directions

Please **circle** the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely. Answers to the following questions are for our records and will be considered confidential.

1. Are you in good health ………………….…………… Yes No
   A. Has there been any change in your general Health…………………………….......................... Yes No
2. My last physical examination was on ____________________
3. Are you now under the care of a physician …………… Yes No
   A. If so, what is the condition being treated.

   ____
4. **The name and address of my physician is:**

   ____

   _________________Phone: ___________________________
5. Have you had a serious illness or operation ……….….. Yes No
   A. If so, what was the illness or operation.:

   ____
6. Have you been hospitalized or had serious illness within the last five (5) years….…………………………......Yes No
   A. Do you have a persistent cough or cough up blood ..……………………………… . ..Yes No
   B. Low blood pressure …….……………………….....Yes No
   C. Venereal disease ………………………….......... Yes No
   D. AIDS or HIV+ ……………………………............ Yes No
   E. Other____
7. Have you had abnormal bleeding associate with previous extractions, surgery, or trauma ……………… Yes No
8. Do you have any blood disorder such as anemia……….. Yes No
9. Have you had surgery or x-rays treatment for a tumor, growth or other conditions your mouth or lips….………Yes No
10. Are you taking any drug or medication …………… ….Yes No
11. Are you taking any of the following:
    A. Antibiotics or sulfa drugs …………………………...Yes No
    B. Anticoagulants (blood thinners) . . …..……………..…Yes No
    C. Medicine for high blood pressure …………….…..…Yes No
    D. Cortisone (steroids) ………….. ……………………Yes No
    E. Tranquilizers ……………………………….……......Yes No
    F. Aspirin ……………………………......................Yes No
    G. Insulin, Tolbutarmide (Orinase) or similar drug….. . Yes No
    H. Digitalis or drugs for heart trouble ……………..…..Yes No
    I. Nitroglycerin …………………………........ ….Yes No
    J. Fen-Phen (now, or in the past)………………..….. . …Yes No
    K. Oral Contraceptives …………………………….. …Yes No
       If so, what are you using:____________________________
    L. Other____
12. Do you have a heart murmur/mitral valve prolaspe…… Yes No
13. Do you have any implants and/or Prosthesis (I.e. knee joint, elbow pins, etc.)…. ………………….. Yes No
14. Do you drink alcoholic beverages ……………………….. Yes No
15. Do you smoke ………………………………................. Yes No
16. Do you have or have you had any of the following

    Diseases or problems :
    A. Rheumatic fever or rheumatic heart disease ……..… … Yes No
    B. Congenital heart lesions ……………………..…..…… Yes No
    C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke) …Yes No
       1) Do you have pain the chest upon exertion………… Yes No
       2) Are you ever short of breath after mild exercise……………….…………….................. .Yes No
       3) Do you have short of breath when you lie down or do you require extra pillows when you sleep………… Yes No
    D. Allergy …………………………........................ .. Yes No
    E. Asthma or hay fever ……………………………... ... Yes No
    F. Hives or skin rash ……………………………............ Yes No
    G. Fainting spells or seizures …………………………….. Yes No
    H. Diabetes ……………………………........................ Yes No
       1) Do you have to urinate (pass water) more than six (6) times a day. . .. ………………….……….Yes No
       2) Are you thirsty much of the time ….…………… ..Yes No

3) Does your mouth frequently become dry ………………….. Yes No
    I. Hepatitis, jaundice, or liver disease …………………..Yes No
    J. Arthritis …………………………..........…...... ...Yes No
    K. Inflammatory rheumatism (painful, swollen joints)..…. Yes No
    L. Stomach ulcers ………………………….................Yes No
    M. Kidney trouble ……………………………………......Yes No
    N. Tuberculoses ………………………………................Yes No
17. Are you allergic or have you reacted adversely to:
    A. Local anesthetic ………………………………..….........Yes No
    B. Penicillin or other antibiotics ……………………… …Yes No
    C. Barbiturates, sedatives, or sleeping pills. . . …..…… . Yes No
    D. Sulfa Drugs ……………………………..................... .Yes No
    E. Aspirin ……………………………....................... ..Yes No
    F. Iodine …………………………….................... ..Yes No

G. Latex …………………………….............................. ..Yes No

H. Other: ____

18. Have you had any serious trouble associated with previous dental treatment …………….. . Yes No
19. Are you pregnant or could you be ? ……………..……… Yes No

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient/Guardian _____________________________ Date____________

Doctor ____________________________________ Date ____________

Comments if any: ____

____

Updates:

Patient/Guardian	Date:	Doctor's Initials	Patient/Guardian	Date:	Doctor's Initials
________________	___________	_________	________________	___________	_________
________________	___________	_________	________________	___________	_________
________________	___________	_________	________________	___________	_________

EXAMINATION WORKSHEET **COMPLETE** **LIMITED PERIODIC**

PATIENT NAME	DATE	DOCTOR / ASSISTANT

TOOTH	PRE-EXISTING	PROBLEM LIST	TREATMENT NEEDED	PRIORITY
1				
2				
3				
4 (A)				
5 (B)				
6 (C)				
7 (D)				
8 (E)				
9 (F)				
10 (G)				
11 (H)				
12 (I)				
13 (J)				
14				
15				
16				
17				
18				
19				
20 (K)				
21 (L)				
22 (M)				
23 (N)				
24 (O)				
25 (P)				
26 (Q)				
27 (R)				
28 (S)				
29 (T)				
30				
31				
32				

	ADDITIONAL TREATMENT RECOMMENDATIONS					
PERIO	Prophy With Fluoride					RECALL
	Full Mouth Debridement					☐ 3 MONTH
	Root Plane	UR	UL	LR	LL	☐ 4 MONTH
	Localized	UR	UL	LR	LL	☐ 6 MONTH
	Irrigation	UR	UL	LR	LL	☐ 12 MONTH
RX	Chlorhexidene Rinse Doxycycline Hyclate Nightguard					
DX	Study Models Oral Images Xrays:___________________					
DENTURE	FUD (AGE, CONDITION) or NEW					
	FLD (AGE, CONDITION) or NEW					
	PUD (AGE, CONDITION) or NEW					
	PLD (AGE, CONDITION) or NEW					
	RELINE/ TISSUE CONDITIONING YES NO					

MEDICAL HISTORY / DENTAL HABITS UPDATE	MEDICAL ALERT
Changes to Medical History /ALLERGIES:	
Current Medications:	
Blood Pressure:	

Current Home Hygiene Habits	Recommended Habits
Toothbrush Type: Manual Power	TYPE TB Manual Power
Brush Teeth 1x 2x 3x 4x daily	TB 1x 2x 3x 4x daily
Floss 1x 2x 3x 4x daily	FLOSS 1x 2x 3x 4x daily
Tongue Care: Brush Scraper	TONGUE Brush Scraper
Rinse: Yes No	
Fluoride Gel: Yes No	
Whitening Gel Yes No Interested	

Patient's Signature:

I've reviewed this patient's Medical Hx, current & recomm Dental Habits

Doctor's Signature:

LAST F/M PERIO PROBING______________ PERIO CHART Y N

GINGIVAL CONDITION:					COMMENTS
COLOR	PINK	LT. RED	DRK. RED	PURPLE	
CONSIST	FIRM	SOFT	FLOPPY		
TEXTURE	STIPPLED		SMOOTH		
MARGINS	KNIFE EDGED		ROLLED		
PAPILLA	SHARP		BLUNT		
CALCULUS					
SUPRA	NONE	LIGHT	MOD.	HEAVY	
SUB	NONE	LIGHT	MOD.	HEAVY	
PLAQUE					
NONE	LIGHT	MODERATE	HEAVY		
ORAL HYGIENE					
GOOD	FAIR	POOR			
PERIODONTAL DX:	LOCAL	GENERALIZED			
Healthy	Gingivitis	Adult Periodontitis			

SOFT TISSUE EXAM			
SALIVARY GLANDS	WNL	PATHOLOGY	
LIP	WNL	PATHOLOGY	
TONGUE	WNL	PATHOLOGY	
FLOOR OF MOUTH	WNL	PATHOLOGY	
FRENUM	WNL	PATHOLOGY	
MUCOSA	WNL	PATHOLOGY	
OROPHARYNX	WNL	PATHOLOGY	
PALATE	WNL	PATHOLOGY	
CANCER SCREENING	WNL	PATHOLOGY	
HEAD & NECK EXAM	WNL	PATHOLOGY	
TMJ EXAM	WNL	POP & CLICK RT. LEFT	PAIN Y N
OCCLUSAL STATUS	CLASS I	CLASS II	CLASS III

REFERRAL	PERIO	ENDO	ORAL SURGERY	ORTHO	PEDO	MD
DOCTOR						
REASON						