

Robert R. Smith, DDS, FAAPD Lily Ghafouri, DMD, MS

Practice Limited to Pediatric Dentistry

9201 Sunset Boulevard, Suite 200

West Hollywood, CA 90069

310-273-5776

Please provide the following confidential PATIENT information:

Name _____

Street Address _____

City _____ ST _____

ZIP _____

School _____ grade _____

Birth date ____/____/____ Age _____

Child's gender: male female

Home phone _____

Cell Phone _____

E-Mail: _____ @ _____

Parents/guardians _____

Parent's marital status _____

Getting to Know you.....

Is the patient a relative of another of our patients?

Who referred you to our office? _____

What is your child's favorite...

t.v. show _____

hobby _____

person _____

Of what is your child most proud? _____

Temperament: Is your child...

shy aggressive happy

Has your child had any unfavorable medical or dental experiences? _____



There's More on the Other Side!

Account Information

Please complete the following information for each parent

Parent's Name _____

Relation to patient _____

Occupation _____

Employer _____

Business phone _____

Social Security # _____

Driver's license _____

Dental Insurance _____

ID # _____ Group# _____

Insured Person [] primary [] secondary

Birth Date: ____/____/____

Parent's Name _____

Relation to patient _____

Occupation _____

Employer _____

Business phone _____

Social Security # _____

Driver's license _____

Dental Insurance _____

ID # _____ Group# _____

Insured Person [] primary [] secondary

Birth Date: ____/____/____

Medical and Dental Information

Please describe what you would like to achieve from today's visit _____

Name of child's pediatrician _____

Address _____

Approximate date of last visit _____

Child's height _____ Child's weight _____

Is the child in good health? _____

Has child a history of any major illnesses? _____

Is the child taking any medications? _____

Is the child allergic to any medications? _____

Does the child have a tendency toward colds or ear infections? _____

Have the child's tonsils or adenoids been removed? _____

Name of child's previous dentist _____

Approximate date of last visit _____

Does your child have speech problems? _____

Is your child a mouth breather at night or day? _____

Does your child suck his or her finger or thumb? _____

Does he or she suck a pacifier or blanket? _____

Are there habits that have been discontinued? _____

How long ago? _____

Have there been injuries to the face or mouth in the past? _____

Have other family members had orthodontic treatment? _____

Please read these conditions carefully and check any that exist in present or past history...

- Diabetes
- Fever blisters
- Heart trouble
- Rheumatic fever
- AIDS, HIV
- Bone disorders
- Tuberculosis
- Seizure disorders
- Asthma
- Chicken pox
- Kidney disorders
- Liver problems
- Endocrine problems
- Prolonged bleeding
- Fainting or dizziness
- Nervous disorders
- Immune disorders
- Neuro-muscular disorders

***Don't forget to complete
the other side***

Consent: The undersigned hereby authorizes Robert R. Smith, DDS or Lily Ghafouri, DMD to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by them to make a thorough and complete diagnosis of my child's dental needs. I also authorize Dr. Smith or Dr. Ghafouri to perform treatments, provide medications and therapies that may be indicated in connection with (print patient's name) _____'s dental health care from now until the time I revoke such consent in writing. I understand that responsibility for payment of dental services in this office for myself or my dependents is mine, due and payable at the time of services being rendered.

Signature _____ Date ___/___/___ Relationship _____



Robert R. Smith, DDS
Lily H. Ghafouri, DMD, MS
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DENTAL INSURANCE & FINANCIAL POLICY DISCLOSURE

Full Payment for all dental services provided in our office is the responsibility of the patient or patient's parent or guardian. If you have a dental insurance plan, we will offer you an *estimate* of what your specific plan may contribute to your payment, but we do not guarantee the accuracy of the estimate. We provide estimates only as a service to help you gauge your share of the cost of care for your child. Please understand that all insurance plans are not equal. Among the different insurance plans and even within the same company, there are considerable differences in rates and allowances and we can only estimate your plan's contribution from tables of allowances provided and we only have tables on file on the insurance companies we are in network with. We have no way of knowing what the allowable fees are for companies with whom we are not contracted.

We submit insurance electronically at the end of the day. It is your responsibility to keep your insurance and personal information current in our files. Your estimated portion will be calculated by the computer and you will be responsible to pay that amount the day of service. *We bill your insurance as a courtesy and you are responsible for any difference in fees.*

PAYMENT IS DUE THE DAY THE SERVICES ARE RENDERED. WE ACCEPT VISA, MC, DISCOVER AND AMERICAN EXPRESS AS WELL AS CASH AND CHECKS. CHECKS ARE NOT ACCEPTED FOR COSMETIC WORK. IF YOU HAVE INSURANCE AND IT DOES NOT PAY THE EXPECTED AMOUNT YOUR PORTION IS DUE WITHIN 30 DAYS. ACCOUNTS OVER 60 DAYS WILL BE CHARGED A \$35 LATE FEE AND ANYTHING OVER 120 DAYS WILL BE TURNED OVER TO COLLECTION.

Thank you!

Robert R. Smith DDS
Lily H. Ghafouri, DMD, MS

I, _____ understand that my insurance plan may contribute a portion of the payments due to Dr. Smith and/or Dr. Ghafouri and that this portion may differ from the computer estimate. Insurance companies do not guarantee the estimates given on the phone. If you have concerns about what your insurance will pay, please request a pretreatment estimate before treatment is done. This usually takes from 2-3 weeks by electronic filing.

We are IN Network with these PPO's: Delta Dental Premier, CIGNA, Ameritus, United Concordia, Guardian, GHEA Connection Dental, & Blue Cross Dental Blue PPO 100, 200 & 300. We are listed under Pediatric Specialists, not under their general dentists. There are many insurance companies that process claims through a 3rd party call Dentmax that we are in network with, so if you have any questions, please call your insurance company.

We are OUT of Network with all other PPO's, including but not limited to Met Life, Blue Cross, Aetna PPO, Blue Shield, Delta DPO other PPO's that allow you to choose your own dentist. We do not accept any HMO plans. **Most PPO's pay a reasonable portion and you can get a copy of what they pay in and out of network on line or from your human resource department or on line at your insurance company's website! We will bill your insurance as a courtesy and you are responsible for any difference in fees.**



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After thirty years in practice, you would think we would have all the answers. The one nagging problem for us is last-minute cancellations and no-shows. Please show us the courtesy of giving us at least twenty-four hours notice before changing an appointment. There are other patients who would love to have your time slot. This is especially important during school holidays and breaks!

For those of you who find it necessary to change at the last minute, please note that there will be a charge of \$65 for each thirty minutes of appointed time. We understand unforeseen emergencies such as illness and the over-turned big rig on the 405 freeway. If you feel you have an excusable emergency, please call the office! Our message machine is on 24/7 and you can always leave a message to be picked up the next business morning. Calls made AFTER the day of the appointment will not have any late fees waived. We only ask that everyone respect the value of our time and the time of our other patients.

Thank you!

Robert R. Smith DDS
Lily H. Ghafouri, DMD, MS

I have read and understand the office cancellation policy.

Parent's Signature



Robert R. Smith, D.D.S., Inc
Robert Smith, DDS
Lily Ghafouri, DMD

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this
Office's Notice of Privacy Practices.

Please print name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
