SEZA BARSAMIAN, DDS, INC

Today's date:_____Patient Name:_____DOB:_____
Date of Last Dental Exam:_____Date of Last Dental Xrays:_____
Are you under physician care: Yes / No Doctors Name:_____ Phone:_____
Have you been hospitalized or had major operations: Yes / No If Yes please explain: _____

_____

List of ALL Medications, pills or drugs:_____

_____

Have you had a serious Head & Neck Injury: _____
Do you use: Tobacco: Yes/ No Alcohol: Yes/ No Controlled Substance: Yes /No Recreational Drugs: Yes/ No
Please List all Allergies: _____
Have you take Fosamax, Boniva, Actonel or any other medications containing Bisphosphonate ?.....Yes / No
For women please indicate if you are pregnant or nursing:_____

Do you have or have you had any of the following/ Please circle all that apply:

AIDS /HIV Positive	Ye	No	High Cholesterol	Yes	No
Alzheimer Disease	Yes	No	Hives or Rash	Yes	No
Anaphylaxis	Yes	No	Hypoglycemia, Low Blood Sugar	Yes	No
Anemia	Yes	No	Hyperglycemia, High Blood Sugar	Yes	No
Arthritis or Gout or Swelling of Joints	Yes	No	Immunodeficiency or Autoimmune Disease	Yes	No
Artificial Joint	Yes	No	Kidney Problems, Dialysis	Yes	No
Artificial Heart Valve	Yes	No	Liver Disease	Yes	No
Asthma	Yes	No	Leukemia/ Lymphoma	Yes	No
Altered Taste or Smell Sensation	Yes	No	Lung Disease	Yes	No
Blood Disease or Hemophilia	Yes	No	Lupus	Yes	No
Blood Transfusion	Yes	No	Mitral Valve Prolapsed	Yes	No
Benign Tumors	Yes	No	Migraine	Yes	No
Breathing Problem	Yes	No	Osteoporosis	Yes	No
Cancer or Chemotherapy or Radiation Treatment	Yes	No	Pace makes/ Irregular hreat beat	Yes	No
Cold Sore/ Fever Blisters	Yes	No	Pain in Jaw Joints/ TMJ/TMD	Yes	No
Congenital Heart Disorders	Yes	No	Parathyroid Disease	Yes	No
Chest Pain/ Angina/MI	Yes	No	Psychiatric Care	Yes	No
Cortisone Medicine, Steroids	Yes	No	Recent Weight Loss or Gain	Yes	No
Diabetes	Yes	No	Respiratory Illnesses/ COVID19 / SARS/ MERSA	Yes	No
Drug Addiction	Yes	No	Rheumatic Fever or Rheumatism	Yes	No
Emphysema	Yes	No	Scarlet Fever	Yes	No
Easily Bruised	Yes	No	Shingles	Yes	No
Epilepsy/ Seizures/ Convulsion	Yes	No	Sickle cell Disease	Yes	No
Fainting Spells/ Dizziness	Yes	No	Sinus Trouble/ Sinusitis/ Sinus surgery	Yes	No
Excessive Thirst	Yes	No	Spinea Bifida	Yes	No
Excessive Bleeding	Yes	No	Stomach or Intestinal problems	Yes	No
Frequent Diarrhea	Yes	No	Stroke, TIA	Yes	No
Frequent Cough	Yes	No	Swelling of Joints/ Limbs	Yes	No
Frequent Headaches	Yes	No	Thyroid Disease/ Parathyroid	Yes	No
Genital Herpes	Yes	No	Tonsillitis	Yes	No
Glaucoma	Yes	No	Tuberculosis/ TB	Yes	No
Hay Fever	Yes	No	Tumors or Growths	Yes	No
Heart Failure	Yes	No	Ulcers	Yes	No
Heart problem / Heart Attack	Yes	No	Venereal Disease	Yes	No
Heart Murmur	Yes	No	Yellow Jaundice	Yes	No
Herpes / type I or II	Yes	No	Other Diseases, Illnesses or Conditions NOT Listed above	Yes	No
Hepatitis A, B, C or D	Yes	No	Please Explain: _____		
Hypertension or High Blood Pressure	Yes	No	_____		
Hypotension or low Blood Pressure	Yes	No	_____		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health or the patient's health. It is my responsibility to inform the dental office of any changes in my medical status.

X_____ Date_____

⇧ Signature of patient / parent or Guardian

Reviewed by Dr Seza Barsamian _____

SEZA BARSAMIAN, DDS, INC

4022 Katella Ave, Suite 206, Los Alamitos, CA 90720
Phone: 562.596.4439

Today's date:_____Preferred Name:_____Age:_____

First Name:_____Last Name:_____ MI:_____

Date of Birth:_____SS#:_____Driver's License #:_____

Address:_____APT#: _____

City:_____Zip: _____

Phone Number we may contact you at: Home:_____

Cell:_____work:_____ext:_____

Email address we may contact you at :_____

Occupation:_____Employed By:_____

Employment Status: ☐ Full time ☐ Part time ☐ Retired How Long:_____

Sex: ☐ F ☐ M Marital Status: ☐ Married, ☐ Single, ☐ Divorced, ☐ Separated, ☐ Widowed

Whom may we thank for your referral:_____
Previous Dentist:_____
Emergency Contact person: _____Relationship:_____
Phone Number:_____

Guardian Name (for Minors only): _____
Relationship to Patient: _____

Insurance Info:

Primary Insurance Company Name:_____ID #:_____
Policy Holder's Name:_____Relationship to Patient:_____
SS# of Policy Holer:_____DOB:_____
Address if different from patient:_____
Employer Name:_____

Secondary Insurance Company Name:_____ID #:_____
Policy Holder's Name:_____Relationship to Patient:_____
SS# of Policy Holer:_____DOB:_____
Address if different from patient:_____
Employer Name:_____

SEZA BARSAMIAN, DDS, INC

Dentist-Patient Arbitration Agreement:

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to Dental malpractice, that is as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the dentist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against dentist, and the dentist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the dentist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the dentist, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received , the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first dental services

_____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____ By: _____ _____

Dentist Signature (Date) Patient's or Patient Representative's Signature (Date)

Dr. Seza Barsamian

_____ _____

Name of Dentist,
Dental Group or Association Name

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

SEZA BARSAMIAN, DDS, INC

4022 Katella Ave, Suite 206, Los Alamitos, CA 90720
Phone: 562.596.4439

Name:_____

Date: _____ DOB:_____

Today's Temperature: _____

Please circle all that apply:

1. In the last 30 days, have you travelled outside the USA? ---------- Yes NO

2. In the last 30 days, have you travelled within the USA? ---------- Yes NO

3. In the 14 days, to your knowledge, have you been in close contact with someone who has travelled outside of the USA?

Yes NO

4. To your knowledge, In the last 14 days, have you been in close contact with someone with a confirmed case of the following?

COVID19 MERS SARS Influenza Unsure NO

5. Are you currently experiencing fever, cough or shortness of breath? ---------- Yes NO

6. Do you have runny nose, sore throat, headaches or muscle pain? ---------- Yes NO

7. Have you had any loss of taste or smell sensation within the last 30 days? ---------- Yes NO

8. Have you been tested for COVID19 (nasal swab test) within the last 30 days ? -------- Yes NO
If yes: when was the test done?_____ Test result_____

9. Have you been tested for COVID19 antibody within the last 30 days ? ---------- Yes NO
If yes: when was the test done?_____ Test result_____

Signature of the Patient:_____

SEZA BARSAMIAN, DDS, INC

4022 Katella Ave, Suite 206, Los Alamitos, CA 90720
Phone: 562.596.4439

Patient Name: _____Date:_____

Consent form for use or Disclosure of Patient Health Information:

I Authorize Seza Barsamian, DDS, Inc to use or disclose my personal information for the purpose of billing. I understand this authorization may be cancelled of modified upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my treatment, payment, enrollment in a health plan, or eligibility of benefits.

Patient Signature X _____

Broken Appointment fee Acknowledgment:

We value our time, any appointments cancelled without a 24 hour notice, or fail to show to an appointment will be subject to a $50.00 BROKEN APPOINTMENT FEE.

Patient Signature X _____

Signed by : ☐ Patient ☐ Parent/ Legal Guardian

☐ Personal Representative of the Patient

Describe the legal authority that permits the representation:

_____