Experience The Difference

of

Dr. Payman Pirnazar's

Specializing in

Preventive & Cosmetic Dentistry

for Infants, Children, Teenagers & Young Adults

Payman Pirnazar, D.D.S., M.S., Inc.
11620 Wilshire Bvld., Suite 720
Los Angeles, CA 90025
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BabyTeeth Children's Dentistry

TESTIMONIALS

"I was very anxious about coming with my son. He had a previous experience which caused him to be anxious. He is very hesitant about all doctors and dentists. My girlfriend referred me and said this would be different. Dr. Piranzar and his staff were so incredibaly kind and patient that I could physically see my son's body relax in the chair. Since then, he has had cavities filled and sealants placed. He loves coming here and says he will keep coming back to the dentist but only if its 'this dentist.' His attitude has helped me make it easier to bring my 2 1/2 year old soon. She actually is excited to come because my son told her how 'fun' it is. I think you guys are amazing! Thank you!"- L.W.

"My son loves visiting Dr. Pirnazar. He's only been a couple of times but whenever he doesn't feel good he says he needs to go to the dentist. I tell him that he needs to see a 'doctor" if his tummy hurts, but he insists the dentist would be better and he's only three! I think everything about BabyTeeth is wonderful."-N.S.

"Dr. P. goes out of his way to make my son feel special, which he responds to."-S.D.

"[My daughter] is very comfortable and secure with you all throughout what has been a difficult process for her. Thank you for that and I'm especially impressed with how you follow-up with calls to check on her after appointments."-J.D

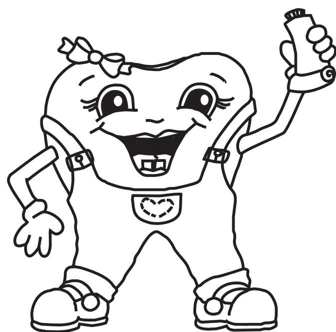
"I went to another Pediatric Dentist before I came to BabyTeeth and I appreciated your staff 's genuine interest and the knowledge Dr. Barcohana possessed on tooth decay and babies. Your staff made me feel very comfortable and even took the time to thoroughly go thru all of my options with my daughter's teeth."-M.M.

"My kids love to go to the dentist [who is Dr. Pirnazar] and I think it is great because dentists were always scary to me, besides being paiful. It is amazing that they look forward to each visit instead of being afraid."-J.A.

"I love the personal attention, willingness to answer questions, and the genuine concern."-M.W.

"You certainly make my 11 year old much more comfortable about his upcoming filling."-S.F.

"Thank you! I am going to send more kids to your office. All of you are EXCELLENT! The doctor is very friendly and knows how to relate to kids."-M.R.



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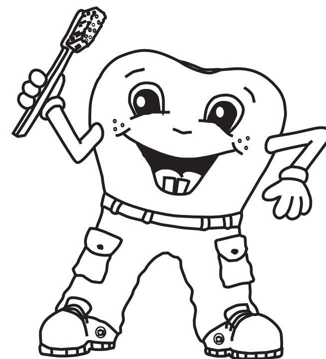


BabyTeeth Children's Dentistry

1 Child's Information

Date: ________________

Child's Name: ____ Preferred name: ________________
first middle last

Sex: ❑ M ❑ F Age: ____ Birthdate: ____ /____ /_____ Place of Birth: ___________ SSN: _____-_____-______

School: __________________________ Grade: _____ City: ___________ E-mail: _________________________

Number of brothers? _______ Number of sisters? _______ Is this child the: ❑ Oldest ❑ Middle ❑ Youngest

Siblings: ❑ Brother ❑ Sister Name ________________ Age _____ Ever a BabyTeeth patient? ❑ Yes ❑ No

❑ Brother ❑ Sister Name ________________ Age _____ Ever a BabyTeeth patient? ❑ Yes ❑ No

❑ Brother ❑ Sister Name ________________ Age _____ Ever a BabyTeeth patient? ❑ Yes ❑ No

❑ Brother ❑ Sister Name ________________ Age _____ Ever a BabyTeeth patient? ❑ Yes ❑ No

Has your child had any bad dental or medical experiences in the past? ❑ No ❑ Yes

If yes, please explain: ____

Please check **any** of the following that may describe your child:

❑ Outgoing ❑ Regular Kid ❑ Shy ❑ Anxious ❑ Hyper ❑ Defiant ❑ Trusting

❑ Suspicious ❑ Cooperative ❑ Mellow ❑ Curious ❑ Stubborn ❑ Friendly ❑ Moody

Child's Interests: ______________________ Favorite Sport: ___________________ Favorite Movie: _____________

How do you expect your child to react to his/her visit today?

❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Don't Know

How can we make this a more positive experience for your child? ____

Whom may we thank for referring you to our office? ____

Who is this? ❑ Dentist ❑ Physician ❑ Teacher ❑ Relative ❑ Friend ❑ Other

❑ Current BabyTeeth patient ❑ Former BabyTeeth patient

2 General Information

Mother's Name: ______________________________
Address: _____________________________________
City: ___________________ State: ____ Zip: _______
Home Phone: (   ) ___________________________
Cell Phone / Pager: (   ) _______________________
E-mail: ______________________________________
Date of Birth: ___ /___ /____ SSN: _____-___- ______
Driver License #: _____________________ State: ____
Occupation: __________________________________
Employer Name: _______________________________
Employer Address: _____________________________
City: ___________________ State: ____ Zip: _______
Work Phone: (   ) ____________________________

Father's Name: ______________________________
Address: _____________________________________
City: ___________________ State: ____ Zip: _______
Home Phone: (   ) ___________________________
Cell Phone / Pager: (   ) _______________________
E-mail: ______________________________________
Date of Birth: ___ /___ /____ SSN: _____-___- ______
Driver License #: _____________________ State: ____
Occupation: __________________________________
Employer Name: _______________________________
Employer Address: _____________________________
City: ___________________ State: ____ Zip: _______
Work Phone: (   ) ____________________________

Who does the child live with? ❑ Both Parents ❑ Mother ❑ Father ❑ Other __________________

Name of person responsible for this account: _________________________________ Relationship: ______________

IN CASE OF EMERGENCY, who should we contact? (Please specify someone who does not live in you household)

Name: ______________________________________ Relationship: __________________________________

Home Phone: (   ) ___________________________ Work Phone: (   ) ____________________________

BabyTeeth Children's Dentistry

3 Dental History

Reason for today's visit: ____________________

❑ Yes ❑ No Is this your child's first dental visit?

If no, date of last visit? ________ Date of last X-rays: ________ Work done: ____________

Name of former dentist: ____________ Phone: ________ ❑ General ❑ Pediatric

❑ Yes ❑ No Was your child breast fed? If Yes, until what age? ____________

❑ Yes ❑ No Was your child bottle fed? If Yes, until what age? ____________

❑ Yes ❑ No Has your child ever had any injuries to his/her: ❑ teeth ❑ mouth ❑ head ❑ jaws

If yes, please describe: ____________________

❑ Yes ❑ No Does your child brush daily?

❑ Yes ❑ No Does an adult assist with the brushing?

❑ Yes ❑ No Does your child floss?

❑ Yes ❑ No Does an adult assist with the flossing?

❑ Yes ❑ No Does your child do any professional modeling? Are esthetics of primary concern?

If yes, please explain: ____________________

Does your child have any of the following mouth habits?

❑ Finger Sucking ❑ Thumb Sucking ❑ Lip Sucking ❑ Tongue Thrusting

❑ Mouth Breathing ❑ Teeth Grinding ❑ Nail Biting ❑ Pacifier ❑ Other: ____________

Does your child receive fluoride in any of the following form?

❑ In Vitamins ❑ In Water Supply ❑ In Toothpaste ❑ In Tablets/Drops ❑ In Rinse/Gel ❑ Other:________

4 Medical History

Child's Pediatrician: ____________ City: ____________ Phone: ____________ Date of Last Physical: ________

❑ Yes ❑ No Is your child in good health?

❑ Yes ❑ No Are your child's immunizations up to date?

❑ Yes ❑ No Does your child need to be premedicated before dental treatment?

❑ Yes ❑ No Is your child being treated for any conditions presently? If so, please explain:____________

❑ Yes ❑ No Does your child have any allergies or reactions to any medications? If so, to what? ____________

❑ Yes ❑ No Has your child ever been hospitalized or had surgery? If so, please explain: ____________

Does your child have any allergies to any of the following?

❑ Pollen ❑ Food ❑ Food Dyes ❑ Dust ❑ Pollen ❑ Other: ____________________

Has your child ever been diagnosed as having any of the following condition?

❑ Yes ❑ No AIDS/Hepatitis
❑ Yes ❑ No Allergies to Medications
❑ Yes ❑ No Anemia
❑ Yes ❑ No Asthma
❑ Yes ❑ No Autism
❑ Yes ❑ No Bladder Conditions
❑ Yes ❑ No Blood Transfusions
❑ Yes ❑ No Bone or Joint Problems
❑ Yes ❑ No Brain Injury
❑ Yes ❑ No Bruising Easily
❑ Yes ❑ No Cancer or Malignancies

❑ Yes ❑ No Chronic Headaches
❑ Yes ❑ No Ear Infections
❑ Yes ❑ No Epilepsy
❑ Yes ❑ No Convulsions/Seizues
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Eye Problems
❑ Yes ❑ No Excessive Gagging
❑ Yes ❑ No Fainting or Dizziness
❑ Yes ❑ No Developmental Delay
❑ Yes ❑ No Hearing/Speech Problems

❑ Yes ❑ No Hyperactivity
❑ Yes ❑ No Kidney/Liver Disease
❑ Yes ❑ No Leukemia
❑ Yes ❑ No Emotional Disturbances
❑ Yes ❑ No Nutritional Deficiency
❑ Yes ❑ No Oral Ulcers
❑ Yes ❑ No Orthopedic Problems
❑ Yes ❑ No Rheumatic Feve
❑ Yes ❑ No Scoliosis
❑ Yes ❑ No Sickle Cell Anemia
❑ Yes ❑ No Spina Bifida

❑ Yes ❑ No Cerebtral Palsy
❑ Yes ❑ No Heart Problmes
❑ Yes ❑ No Child/sexual Abuse
❑ Yes ❑ No Hemophilia
❑ Yes ❑ No Tonsil Problems
❑ Yes ❑ No Syndrome ________
❑ Yes ❑ No Other: ________

Please describe any current medical treatment including drugs, pending surgery, recent injuries, hospitalizations or any other information we should be aware of that has not been covered: ____________________

BabyTeeth Children's Dentistry

PATIENT CONSENT & AUTHORIZATION FORM

I, the undersigned, ____, have

had the treatment plan(s) for ____ explained to me.

The risks involved with those procedures, alternatives to those procedures, risk therein involved, and the risks of no treatment have also been explained to me and I understand the explanations. I have been given an opportunity to ask questions and have those questions answered.

Based upon these explanations, I have agreed that ____________________________________ be treated at BabyTeeth Children's Dentistry, according to the treatment plan and:

a. Authorize the administration of local anesthetic and/or nitrous oxide analgesia deemed necessary for the performance of dental procedures.

b. Authorize the taking of any records, x-rays, or photographs as is deemed necessary in the treatment and the use of such records, x-rays, or photographs by BabyTeeth Children's Dentistry, its doctors, staff, or any other entity authorized by BabyTeeth Children's Dentistry.

c. Acknowledge that all original records and diagnostic aids are the property of BabyTeeth Children's Dentistry. Copies may be furnished upon written request based on established policies of the office. There may be a fee for duplication and/or transfer of records.

d. Grant permission to BabyTeeth Children's Dentistry, its doctors, staff, or any other entity authorized by BabyTeeth Children's Dentistry to reproduce, or use at its sole discretion, any records, x-ray, data, images, or photographs in any form or by any means for the purpose of illustration or publication on, but not limited to, our web site (BabyTeeth Online), in professional journals, or any other type of media. I understand that any and all of such media will be copyrighted property of BabyTeeth Children's Dentistry, its doctors, staff, or other entity authorized by BabyTeeth Children's Dentistry. Whenever possible, data, records, and diagnostic aids used for purposes other than normal outpatient clinical operation will not contain identifying information.

e. I authorize the transmission, electronic or other means, of data for payment or communication purposes including but not limited to insurance companies. I acknowledge I have received and/or reviewed a copy of the Dental Materials Fact Sheet and Patient Privacy Notice.

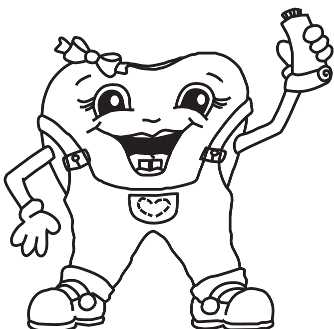
f. Acknowledge that appointments are scheduled in advance. It is essential, therefore, that all appointments be kept promptly. In the event that an appointment cannot be kept, I will notify BabyTeeth Children's Dentistry at least 2 business days in advance, so that my appointment can be rescheduled or a missed appointment fee may be charged. BabyTeeth Children's Dentistry reserves the right to discontinue treatment if, in its sole opinion, circumstances justify such action. Among reasons for discontinuation of treatment are repeated lateness and failure to keep appointments. I will provide the same courtesy to the office staff and other patients which I expect in return.

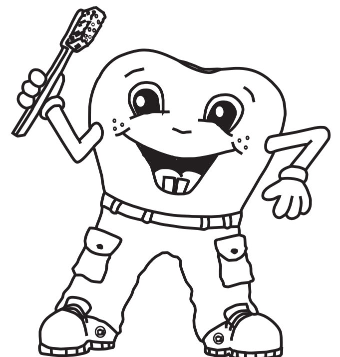
Name of Patient: ____

Name of Parent or Guardian: ____________________________________

Signature of Parent or Guardian: _________________________________

Relationship: ______________________ Date: ___________________





BabyTeeth Children's Dentistry

PAYMENT OPTIONS

Welcome to BabyTeeth Children's Dentistry! We are dedicated to providing the finest care and service for your children.

In order to make payment for services as convenient as possible for you while at the same time maintaining our office in the highest standard of comprehensive care, we offer the following payment options. We will attempt to give you an accurate *estimate* of your total fees at the onset of your child's treatment which will be updated as needed.

Plan A: Payment of fees at the end of each appointment for treatment provided at that appointment.

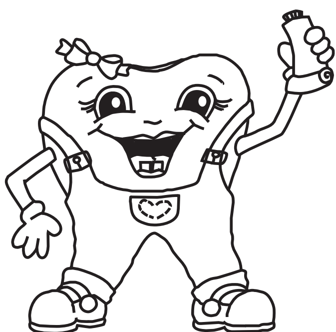
Plan B: Total payment of fees prior to commencement of treatment. Since immediate payment reduces our bookkeeping expenses, a five (5) percent reduction of the fee will be given. Patients treated under sedation, or receiving other discounts are not eligible for this reduction.

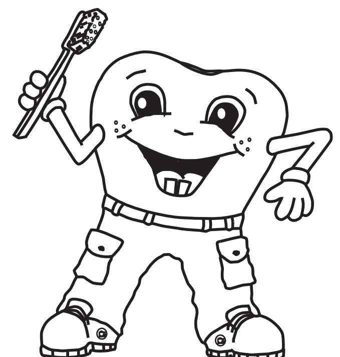
Plan C: 3rd-Party Financing Plan. Please ask our Office Manager for further details including:

- Fast, confidential application process via phone, fax, or internet
- Low, fixed interest rates

For your convenience, we offer the following methods of payment:

- Cash
- Check
- Credit Cards: Mastercard, Visa, American Express
- BabyTeeth Gift Certificates





BabyTeeth Children's Dentistry

FINANCIAL INFORMATION, TERMS AND CONDITIONS

Welcome to BabyTeeth Children's Dentistry! We are dedicated to providing the finest care and service possible. In order to make payment for services as convenient as possible for you while at the same time maintaining our office in the highest standard of comprehensive care, please read the following information, terms and conditions.

These terms apply to all patients, including those who carry dental insurance. BabyTeeth Children's Dentistry may not directly participate with your dental insurance plans. However to help you utilize your insurance benefits, at your request, we may submit a benefits claim form to your insurance company on your behalf. If we choose not to accept assignment of benefits, it is our policy to instruct insurance companies to send insurance payments directly to the subscriber. We accept no responsibility in the collection of any insurance claims or in the negotiation of any settlements on disputed claims. In the event we receive any overpayment on your account by your insurance company, we will either credit your account or issue a refund check, when requested.

In the situation involving divorced or separated parents, the person who has signed for consent for treatment will be held responsible for costs incurred during a child's dental treatment. If the guarantor (the party responsible for the account) differs from the party who has signed for consent, please inform the receptionist **prior** to treatment.
In consideration of the professional services rendered, you agree to accept responsibility for the payment of such services and agree to pay all cost and reasonable attorney fees incurred by your failure to remit for services rendered. You authorize BabyTeeth Children's Dentistry to charge the credit card provided for any payments due. You grant permission to BabyTeeth Children's Dentistry, or its assigns, to contact you at home or work to discuss matters related to this form and account.

As a condition of treatment by BabyTeeth Children's Dentistry, all fees must be paid at the time the service is performed. Payment may be by cash, check or credit card. Any other payment arrangement must be authorized by the office manager in advance. Any account balance over 30 days may be charged to the credit card you have provided below, plus interest, at a rate of 2% per month (24% per year), and/or late fees, service charges where applicable. Fees estimated for proposed dental services are honored for a period of 30 days from the date of the treatment plan.

By signing below, I declare that I have read the above conditions of treatment and agree in content.

Name: ________________________ Signature: _________________________ Date: ____________

CREDIT CARD ON-FILE INFORMATION

Please provide us with one of the following:

❑ VISA #: ___________________ ❑ MASTERCARD #: ___________________ ❑ AmEx #: ___________________

Expiration Date(month/year): __ / __ Security Code: ________

Billing Address of Card : ____________________________, ________________________, _________, ____________

Street Address City State Zip Code

Name of Cardholder: ____

Signature:____