Mona Goodarzi, DDS, Dental Corporation
Siamak Abai DDS, MMedSc, Dental Corporation
16300 Sand Canyon Ave., Suite 506 | Irvine, CA 92618

I, _____, consent to be a patient at the above-named practice(s) and agree to a radiographic and clinical examination.

Furthermore, I also understand and consent to the following (please initial each item line):

— During the course of my treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

— I will provide a thorough and complete medical history, allergies, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

— I understand no guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

— I understand my treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

— I authorize the dentist and/or staff to release any information including, but not limited to, the diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance carriers, payers, and /or healthcare practitioners. I authorize the payment from my insurance carrier to be submitted directly to the dentist/dental practice to be applied directly to any outstanding balance on my account.

— I agree to pay in full any cost of treatment or insurance co-payments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for any costs that my insurance does not cover.

— I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

— I authorize this office to use any pictures, x-rays or videos of me in an anonymous format for patient education and /or marketing purposes in office or on the world wide web.

— I authorize this office, its doctors and staff, to contact me on the email address, and phone number(s) I have provided to them, including my cell phone, to discuss treatment, account balance, and insurance information.

— I authorize this office to send me statements via email and/or text on the email address and cell phone number provided by me.

— I understand the offices missed appointment / short notice cancellation policy (less than 48 hours) is a $50 charge for routine appointments and 20% of treatment cost for extensive 2 hours or longer appointments.

— By signing below, I agree that I have read and understood all of what is written above and have given an opportunity to ask any questions and my question(s) were answered to my satisfaction.

Patient's or Guardian's Name Signature Date