



Patient Information

Name _____ Date _____
Social Security # _____ Birthday _____
Email Address _____
Home Phone _____ Cell Phone _____
Address _____

Referral Information

How did you hear about us?

Newspaper _____ Google _____ Internet _____ Friend / Name _____ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: Patient's Spouse Person Responsible for payment
 Male Female Single Married Divorced Widowed

Name _____

Social Security # _____ Birth Date: _____

Phone (HOME) _____ (work) _____ (ext) _____ Best time to call _____

Address _____

Who should be contacted in case of emergency _____

Employment Information

The following is for: Patient Person Responsible for payment

Employer Name: _____ Occupation: _____

Address _____ WORK Phone: _____

Insurance Information

Name of Insured: _____ Is insured a patient? _____

Insured's Birth Date: _____ ID # _____ Group # _____

Insured's Address: _____

Employer's Name: _____ Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Medical History

Are you taking any recreational drugs (marijuana, cocaine, etc.)? _____

Have you taken FEN-PHEN or REDUX or PONDIMIN? _____ Yes No

Do you wear a cardiac pacemaker, or have you had heart surgery? _____

Are you sensitive or allergic to:

Penicillin erythromycin Tetracycline Sulfa Drugs Aspirin Codeine Latex

Health Information

Date of Last Dental Visit: _____ Reason for Visit: _____

Have you ever had any of the following?

Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pacemaker _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heat Murmur | <input type="checkbox"/> Due Date: | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Phen-Fen |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Sinus Problems | |

- Are you taking any medications? Yes No
If Yes, please explain: _____
- Have you ever had any complications following dental treatment? Yes No
If Yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If Yes, please explain: _____
- Are you now under the care of a physician? Yes No
If Yes, please explain: _____
- Do you have any health problems that need further clarification? Yes No
If Yes, please explain: _____

**To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.**

Signature of patient, parent or guardian _____ Date: _____

- Do you feel nervous about having dental treatment? _____ Yes No
- Have you ever had a local anesthetic? _____ Yes No
- Have you ever had an unfavorable reaction from a local anesthetic? _____ Yes No
- Have you ever had serious trouble associated with previous dental treatment? _____ Yes No
- How long since your last full mouth x-rays? _____ Yes No
- Have you been treated with Orthodontics in the past? _____ Yes No
- Do you want straighter teeth? _____ Yes No
- Are you dissatisfied with the appearance of your teeth? _____ Yes No
- If you could have your teeth whitened, would you be interested? _____ Yes No
- Would you be interested in sleep dentistry? _____ Yes No
- Is there anything else about having dental treatment that bothers you? _____ Yes No

Consent for Services

Ask a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account; However, this dental office cannot render services on the assumption that are charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written Financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said service shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further or condition and I further agree to pay all costs and reasonable attorney fees of suit be instituted hereunder.

Notice of Privacy Practice: You have the right to read the Notice of Privacy Practices which provides a description of office treatment, payment activities and healthcare operations, of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use your photos for demonstration purposes. **Patient Rights:** You have a right to look at or get copies of your health information, with limited exceptions. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Date: _____ Relationship to Patient: _____

Dentist-Patient Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to dental malpractice that is as to whether and dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by my 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 such dispute decided in a court of law before a jury, and instead are accepting the use of arbitrator.

Article 2: All claims must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claim may arise out of or relate to treatment or service provided by the dentist including the 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 claim for monetary damages exceeding the jurisdictional limit of the small claims court against the dentist, and the dentist's partner, associated, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing any action in any Court be the dentist to collect any fee from the patient shall not waive the right to compel arbitrator of any malpractice claim.

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 days of a demand for a neutral arbitrator, together with other expenses of the arbitration shall pay such party's pro rate share of the expenses and fees of the neutral, together with other expenses of the arbitration incurred of 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 issue 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 and 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 Procedures Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2 Civil Procedures. Discovery shall be conducted pursuant to Code of Civil Procedures section 1283.05; however, depositions may be taken without 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 dentist within 30 days of signature. It is the intent of this agreement to apply to all dental 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's representative's Initials

If any provisions 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: _____
Dentist or Authorized Representative's Signature (date)

By: _____
Patient's or Patient's Representative's Signature (date)

By: _____
Print patient's Name

Print or Stamp Name of Dentist, Dental Group or Association Name

(If Representative, Print Name and Relationship to Patient)

INFORMED CONSENT

PATIENT NAME _____ CHART NO _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings _____ Bridges _____ Crowns _____ Extractions _____ Impacted Teeth Removal _____ Root Canal _____ Dentures _____ Partials _____ Periodontics _____ Other _____ X Rays _____ (Initials _____)

2. DRUG AND MEDICATION

I understand that antibiotics, analgesics and other medications can cause allergic reaction causing redness and swelling of tissue, pain, vomiting, and/or anaphylactic shock (severe allergic reaction) (Initials _____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on teeth that were not discovered during examination. I give permission to the dentist to make those changes as necessary. (Initials _____)

4. REMOVAL OF TEETH

Alternative to removal have been explained (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth _____ and any others necessary under paragraph #3. I understand that removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry sockets, loss of feeling in my teeth, lips, tongue and surrounding tissue (parasthesia) that can last for an indefinite period of time or fractured jaw. I understand that I may need further treatment by a specialists or even hospitalization if complications arise during or following treatment. _____

5. ANESTHESIA

I realize the risk involved in receiving a local anesthetic, some of which are: partial face paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage and/or numbness _____

6. CROWNS (CAPS) AND BRIDGES

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns/onlays, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns/onlays are delivered, and that if I don't have the permanent crowns/onlays placed, permanent serious damage or loss of the tooth/teeth involved may ensure, and that if I delay placement I may cause the teeth involved to move so that the permanent crown/onlay no longer fit properly. _____

7. DENTURES - COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone change. _____

8. ENDODONTIC TREATMENT (ROOT CANAL)

Root canal treatment is a procedure to retain a tooth that may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure so there is no guarantee that root canal treatment will save my tooth and complications can occur from the treatment-occasionally metal objects are cemented in the tooth or extended through the root which does not necessarily effect success of the treatment. The treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if I do not complete the prescribed treatment. ,Occasionally a tooth, which has had root canal therapy, may require retreatment, surgery or even extractions. _____

9. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have serious condition, causing gum and bone inflammation and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacement and/or extraction. _____

10. I hereby request and authorize the Dentists, and their staff, to perform dental work upon me for the purpose of attempting to improve the appearance, function and health of my mouth,teeth, bone and tissues, as explained above.

The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me.

I also authorize the operating Dentist and assistants to perform any other procedure, which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of Dentistry and surgery is not an exact science and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone during the treatment that I have herein requested and authorized.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WHERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature: _____
Patient or Legal Representative

Date: _____

Witness: _____

Date: _____

Doctor: _____

Date: _____