WELCOME TO LA VERNE DENTAL & IMPLANT

(This information is NECESSARY for our files and is CONFIDENTIAL)

PATIENT INFORMATION:

_____ _____ _____ _____ _____ Male / Female

Last Name First Name Age DOB SSN

_____ _____ (___)_____ (___)_____ _____

Home Address City, State, Zip Home Phone Cell Phone Email

_____ _____ _____ (___)_____

Employer Name Address City, State, Zip Work Phone

PARENT/GUARDIAN INFORMATION:

_____ _____ _____ _____ _____ Male / Female

Last Name First Name Age DOB SSN

_____ _____ (___)_____ (___)_____ _____

Home Address City, State, Zip Home Phone Cell Phone Email

_____ _____ _____ (___)_____

Employer Name Address City, State, Zip Work Phone

TELL US ABOUT YOURSELF!

Are you interested in (please circle all that apply): Teeth Whitening Implants A Nicer Smile Fresher Breath Healthy Gums

Rate your smile from 1-10 (10 being the best): 1 2 3 4 5 6 7 8 9 10

What would change about your smile? _____

How did you hear about us? _____

Persons living with you:

_____ _____ _____ _____ _____ Male / Female

Last Name First Name Age DOB Relationship

_____ _____ _____ _____ _____ Male / Female

Last Name First Name Age DOB Relationship

_____ _____ _____ _____ _____ Male / Female

Last Name First Name Age DOB Relationship

_____ _____ _____ _____ _____ Male / Female

Last Name First Name Age DOB Relationship

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

_____ _____ (___)_____ (___)_____

Name City, State, Zip Home Phone Cell Phone Email

FINANCIAL INFORMATION Payment Type: Cash Visa/Mastercard Carecredit Other:_____

Primary Insured:

_____ _____ _____ _____ _____ Male / Female

Last Name First Name Age DOB SSN

_____ (___)_____ _____

Insurance Company Eligibility Phone Subscriber ID

Secondary Insured:

_____ _____ _____ _____ _____ Male / Female

Last Name First Name Age DOB SSN

_____ (___)_____ _____

Insurance Company Eligibility Phone Subscriber ID

Health Questionnaire

Patient's Name: _____ Date: _____ DOB:_____

Sex: _____ Height: _____ Weight: _____ Occupation: _____ Marital Status: _____

Please check/circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely. Answers to the following questions are for our records and will be considered confidential.

1. Are you in good health? ☐Yes ☐No
   A. Has there been any change in your general health? ☐ Yes ☐No
2. My last physical examination was on: _____
   _____
3. Are you now under the care of a physician? ☐Yes ☐No
4. The name and address of my physician is: _____
   _____
5. Have you ever had a serious illness or operation? ☐Yes ☐No
6. Have you been hospitalized with any of the following within the last five years:
   A. Persistent cough or cough up blood? ☐Yes ☐No
   B. Low/High blood pressure (circle one) ☐Yes ☐No
   C. Venereal Disease ☐Yes ☐No
   D. AIDS or HIV+ ☐Yes ☐No
   E. Other _____
   _____
7. Have you had abnormal bleeding associated with previous extraction, surgery, or trauma? ☐Yes ☐No
   A. Do you bruise easily? ☐Yes ☐No
   B. Have you ever required a blood transfusion? ☐Yes ☐No
   (If yes, why) _____
   _____
8. Do you have any blood disorder such as anemia? ☐Yes ☐No
9. Have you had surgery or x-ray treatment for a tumor growth or other condition of your mouth or lips? ☐Yes ☐No
10. Are you taking any drug or medication? ☐Yes ☐No
    (If yes, what) _____
11. Are you taking any of the following:
    A. Antibiotics or sulfa drugs ☐Yes ☐No
    B. Anticoagulants (blood thinners) ☐Yes ☐No
    C. Medicine for high blood pressure ☐Yes ☐No
    D. Cortisone (steroids) ☐Yes ☐No
    F. Aspirin ☐Yes ☐No
    G. Insulin, Tolbutamide (Orinase) or similar drug ☐Yes ☐No
    H. Digitalis or drugs for heart trouble ☐Yes ☐No
    I. Nitroglycerin ☐Yes ☐No
    J. Fen-Phen (now or in the past) or related drug such as Ionimin, Adipex, Phentermine, Fastin, Podimimin (Fenfluramine), and Redux (dexfenfluramine) ☐Yes ☐No
    K. Oral Contraceptive ☐Yes ☐No
    (If yes, what are you using?) _____
    L. Chemotherapy Drugs ☐Yes ☐No
    M. Osteoporosis Drug (Fosamax, etc.)? ☐Yes ☐No
    N. Other _____ ☐Yes ☐No
12. Do you have a heart murmur/mitral valve prolapse? ☐Yes ☐No
13. Do you have any implants and/or Artificial Joints (i.e knee joint, elbow pins, ect.?) _____ ☐Yes ☐No
14. Do you drink alcoholic beverages? ☐Yes ☐No
15. Do you smoke? ☐Yes ☐No
    (If yes, how much?) _____
16. Do you have, or had, any of the following diseases or problems:
    A. Rheumatic fever or rheumatic heart disease ☐Yes ☐No
    B. Congenital heart lesions ☐Yes ☐No
    C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)? ☐Yes ☐No
       1. Do you have pain in the chest upon exertion? ☐Yes ☐No
       2. Are you ever short of breath after mild exercise? ☐Yes ☐No
       3. Do you get short of breath when you lie down or do you require extra pillows when you sleep? ☐Yes ☐No
    D. Allergy ☐Yes ☐No
    E. Asthma or hay fever ☐Yes ☐No
    F. Hives or skin rash ☐Yes ☐No
    G. Fainting spells or seizures ☐Yes ☐No
    H. Diabetes ☐Yes ☐No
       1. Do you have to urinate (pass water) more than six times a day? ☐Yes ☐No
       2. Are you thirsty much of the time? ☐Yes ☐No
       3. Does your mouth frequently become dry? ☐Yes ☐No
    I. Hepatitis, jaundice, or liver disease ☐Yes ☐No
    J. Arthritis ☐Yes ☐No
    K. Inflammatory rheumatism (painful, swollen joints) ☐Yes ☐No
    L. Stomach ulcers ☐Yes ☐No
    M. Kidney trouble ☐Yes ☐No
    N. Tuberculosis ☐Yes ☐No
17. Are you allergic or have you reacted adversely to:
    A. Local anesthetic ☐Yes ☐No
    B. Penicillin or other antibiotics ☐Yes ☐No
    C. Barbiturates, sedatives, or sleeping pills ☐Yes ☐No
    D. Sulfa Drugs ☐Yes ☐No
    E. Aspirin ☐Yes ☐No
    F. Iodine ☐Yes ☐No
    G. Latex ☐Yes ☐No
    H. Other _____ ☐Yes ☐No
    _____
18. Have you had any serious trouble associated with previous dental treatment? ☐Yes ☐No
    (If yes, explain…) _____
    _____
19. Are you pregnant or could you be? ☐Yes ☐No
    (If yes, when are you due?) _____

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

_____
Patient/Guardian Signature Date

_____
Doctor Signature Date

Update: 2nd Year / 3Year

Patient/Guardian Signature Date Dr.'s Initials

Patient Guardian Signature Date Dr.'s Initials

Update: 4th Year / 5th Year

Patient/Guardian Signature Date Dr.'s Initials

Patient Guardian Signature Date Dr.'s Initials

LA VERNE
Dental & Implant Center

OFFICE POLICIES

Welcome to La Verne Dental and Implant Center! We are excited to have you as our lifelong patient! It is our general goal to provide you with the highest quality dentistry and care possible, in a courteous and efficient manner. In order to achieve this goal, we ask that you read and agree to the following office policies:

GENERAL AND HYGIENE APPOINTMENTS

We request that you notify our office a minimum of 48 hours prior to your appointment if you need to cancel, change, or reschedule. This will allow us to schedule other patients that need to be seen on an urgent basis. Patients will be charged a $30 cancellation fee for appointments cancelled/rescheduled with less than a 48 hours notice.

SPECIALTY APPOINTMENTS

We require a $200 deposit for all surgical appointments with our specialists. This deposit needs to be paid at LEAST 1 week (7 calendar days) prior to the surgical procedure, otherwise, the appointment will be released and you will not be seen. If the appointment is not cancelled with at least 5 days notice or the patient fails to show to the appointment, the deposit will be kept as a cancellation fee.

TREATMENT PLAN

We will provide you with a treatment plan that outlines the services that the doctor has diagnosed. The treatment plan will show the ESTIMATE and is not a guarantee of payment by your insurance company. Therefore, you may still have a balance once your insurance has issued payment.

FINANCIAL POLICY

Your payment is expected in FULL at the time services are rendered. Payment should be made when checking in to your appointment, prior to receiving any treatment. It is the patient's responsibility to notify us if there is a change in insurance plan(s) and or benefits. Should your account become delinquent for more than 60 days, a finance charge of $50 or 5% (the greater of the two) per month will apply. If your account should be referred to an attorney or collection agency, the undersigned shall be responsible for ALL fees incurred in the collection process.

PAYMENT OPTIONS

For your convenience, our office accepts the following forms of payment:

- All major credit cards (VISA, MASTERCARD, AMEX, DISCOVER)
- Cash
- NO CHECKS PLEASE!

LA VERNE
Dental & Implant Center

TERMS AND CONDITIONS

As a condition of treatment by La Verne Dental and Implant Center, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs 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 service performed without prior financial arrangements, must be paid for at the time services are rendered. I understand that the dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will HELP prepare my insurance forms to assist in making collections from my insurance company(s) and will credit such collections to my account. However, this dental office does not prescribe nor render services on the assumption that charges will be paid by my insurance company.

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to pay directly to my dental benefits accrued to me under my policy. I understand that the fee estimate listed for this dental case can only be extended for a period of 30 days from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by La Verne Dental and Implant Center, I agree to pay, therefore, the value of such services to La Verne Dental and Implant Center at the time services are rendered. I further agree that the value of such services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for the services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees. I grant permission to La Verne Dental and Implant Center to telephone me at home or work and/or via text and email to discuss matters related to my dental care. I have read the above conditions of treatment and agree to their content.

Signature of Patient/Parent/Legal Guardian Date

DENTAL TREATMENT CONSENT FORM

Please read and initial the items below
and read and sign the section at the bottom of form. Patient Name _____

1. WORK TO BE DONE

I understand that I am having the following work done: Exam __X__ Fillings _____ Bridges _____ Crowns _____ Extractions _____ Impacted teeth removed _____ Local Anesthesia _____ Root Canals _____ Other _____

(Initials _____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, 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 or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(Initials _____)

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw,. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. **(Initials _____)**

5. CROWNS 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, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, or bridge (including shape, fit, size, and color) will be before final cementation. **(Initial _____)**

6. 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. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. **(Initial _____)**

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). **(Initial _____)**

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements an/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initial _____)

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____

LA VERNE
Dental & Implant Center

DENTAL SERVICES AGREEMENT

"Doctor" and the undersigned patient ("Patient") have agreed as follows:

ARTICLE 1. IT IS UNDERSTOOD THAT ANY DISPUTE AS TO DENTAL MALPRACTICE THAT IS 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 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 RIGHT TO HAVE SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION.

ARTICLE 2. In the event of any claim, demand, controversy or dispute the essential nature of which involves personal injury, malpractice of any sort, by patient, his/her dependents, whether or not minors, heirs at law or personal representatives against Doctor, any of Doctor's officers, directors, shareholders, agents, representatives, employees, successors in interests, assigns, associates and/or specialists agreeing in writing to be bound by the arbitration provisions of this agreement ("Affiliates"), THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION IN accordance with commercial Arbitration Rules of the American Arbitration Association. The parties hereby agree that they shall submit their controversy to an Arbitrator who is a Dentist licensed in California. Such Arbitrator shall be acceptable to both parties. In the event that the parties cannot agree upon a sole Arbitrator, each party shall pick an Arbitrator who is a Dentist licensed in California and the two Arbitrators shall pick a third Dentist proceeding under the rules of the American Arbitration Association. Notwithstanding the foregoing, two additional Arbitrators who are Dentists may be added by the parties by agreement in writing to create an arbitration panel of three. It is agreed that all parties relevant to a full and complete settlement of any dispute subject to this agreement may be intervene of joined.

ARTICLE 3. The prevailing party in any arbitration pursuant to this agreement shall be awarded all costs, including reasonable attorney's fee and Arbitrators' fees, in prosecuting or defending that claim in arbitration, but not to exceed $5000 in amount. Furthermore, if any action is undertaken to set aside or otherwise attack the binding arbitration award, the losing party in the court action shall bear all the prevailing party's costs, including reasonable attorneys' fees.

ARTICLE 4. Any party initiating arbitration under this agreement shall file with his/her petition a bond or cash surety in an amount equal to $500 which shall provide security for attorney's fees and costs in the event that the moving party shall prevail.

ARTICLE 5. This agreement shall govern all future services rendered to Patient by Doctor, Doctor's Affiliates, Associates and Specialists. Execution of this agreement is a precondition to the furnishing of services by Doctor, Doctor's Affiliates, Associates and Specialists, but this agreement may be rescinded by written notice by either party within thirty days of signature. After those thirty days, this agreement may be changed or revoked only written revocation signed by both parties.

ARTICLE 6. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I understand that no other dentist other than the treating dentist is responsible for my dental treatment.

ARTICLE 7. Doctor, Doctor's Affiliates, Associates and Specialists hereby agree to render dental care and service to Patient. Patient agrees to pay Doctor, Doctor's Affiliates, Associates and Specialists promptly upon the rendering of a bill at the currently prevailing rates, or to cooperate with Doctor, Doctor's Affiliates, Associates and Specialists in obtaining payment from third party payers.

ARTICLE 8. Except for the fact that Doctor, Doctor's Affiliates, Associates and Specialists has indicated professional services will not be rendered to patient unless this agreement is executed, Doctor, Doctor's Affiliates, Associates and Specialists has made no other representations or statement, oral or written, to induce Patient to execute his agreement.

ARTICLE 9. In the event that any provision of this agreement shall be void or unenforceable for any reason whatsoever, then such provision shall be stricken and of no force and effect. The remaining provisions of this agreement, however, shall continue in full force and effect, and to the extent required, shall be modified to preserve their validity. This agreement shall be governed by California law.

THIS IS A BINDING LEGAL DOCUMENT WHICH MAY HAVE AN IMPORTANT EFFECT ON YOUR LEGAL RIGHTS. CONSULT YOUR ATTORNEY ON ANY QUESTIONS YOU MAY HAVE.
NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____	_____	_____
PATIENT'S SIGNATURE	PATIENTS' AGENT OR REPRESENTATIVE	RELATIONSHIP TO PATIENT

_____
DATE

2488 Foothill Blvd., Suite C, La Verne, CA 91750