PATIENT INFORMATION *(PLEASE FILL OUT COMPLETELY)*

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Patient is (circle): Policy Holder Responsible Party Child

Address: _____ City, State and Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Birth Date: _____ Gender: _____ Social Security Number: _____

Employment Status *(circle)*: Full Time Part Time Retired Self Employed Other

Marital Status *(circle)*: Child Single Married Divorced Widowed Separated Other

Student Statues *(circle)*: Full Time Part Time School/Employer Name: _____

Preferred Pharmacy: _____ Address: _____ Phone: _____

PARENT/GUARDIAN INFORMATION *(For minors 17 years & younger)*

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Patient is (circle): Policy Holder Responsible Party Child

Address: _____ City, State and Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Relationship to Patient: _____

Birth Date: _____ Social Security Number: _____ Drivers Lic.: _____

Employment Status *(circle)*: Full Time Part Time Retired Self Employed Other

Marital Status *(circle)*: Child Single Married Divorced Widowed Separated Other

PRIMARY INSURANCE *(IF APPLICABLE, PLEASE FILL OUT COMPLETELY)*

Name of Insured: _____ Relation to Insured: Self Spouse Child Other

Insured ID/SSN: _____ Insured DOB: _____ Ins. Company: _____

Employer: _____ Address: _____

City, State and Zip: _____ Phone: _____

REFERRAL SOURCE *(WHO CAN WE THANK? - Circle)*

Website Social Media Drive By/Walk In Event (which event?) _____

Patient/Friend (who?) _____ Employee (who?) _____ Other (please explain) _____

Print **Signature of Patient/Guardian** **Date**

DENTAL HISTORY

Name (First, Last): _____ Date of Birth: _____

How may we help you today? _____

Your current health is:	Good	Fair	Poor
Do you require antibiotics before dental treatment?		Yes	No
Are you currently in pain?		Yes	No
Have you ever had gum treatment?		Yes	No
Do you now or have you had any pain/discomfort jaw joint? (TMJ)		Yes	No
Are you under any stress? (i.e. new job, moving, relationships)		Yes	No
Do you like your smiles?		Yes	No
Are you happy with the color of your teeth?		Yes	No
Do your gums bleed?		Yes	No
How many do you:	floss/week? _____	brush/day? _____	
Are you sensitive to heat, cold or anything else?		Yes	No
Have you lost any permanent teeth?		Yes	No
Do you grind or clench your teeth?		Yes	No
Have you ever had a serious/difficult problem with and previous dental work?		Yes	No
Have you ever had any unfavorable dental experiences?		Yes	No
When was your last:	Cleaning? _____	Dental Visit? _____	

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at Smiles West we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below that you would like our friendly staff to discuss with you during your visit:

Zoom! Teeth Whitening	Veneers/Lumineers	Bonding	Fixing Chipped Teeth	Smile Makeover
Implant Crowns	Partials/Dentures	Straight Teeth	Replace Silver Fillings	Crowns & Bridges

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party health practitioners. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I agree to be responsible for any payments of services being rendered on my behalf or my dependents.

Print **Signature of Patient/Guardian** **Date**

PATIENT HEALTH HISTORY

Although dental personnel primarily treat in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following:

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medication, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes, please explain: _____
Are you on a special diet?	Yes	No	If yes, please explain: _____
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

WOMEN, ARE YOU *(circle)*…

Pregnant/trying to get pregnant? Yes No Taking Oral Contraceptives? Yes No Nursing? Yes No

ARE YOU ALLERGIC TO THE FOLLOWING *(circle)*…

Asprin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other, please explain: _____ None

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING…

AIDS/HIV Positive	Yes	No	Excessive Thirst	Yes	No	Pain in Jaw Joint	Yes	No
Alzheimer's Disease	Yes	No	Fainting Spells/Dizziness	Yes	No	Parathyroid Disease	Yes	No
Anaphylaxis	Yes	No	Frequent Cough	Yes	No	Pins/Rods/Stunts/Shunts	Yes	No
Anemia	Yes	No	Frequent Diarrhea	Yes	No	Psychiatric Care	Yes	No
Angina	Yes	No	Frequent Headaches	Yes	No	Radiation Treatments	Yes	No
Arthritis/Gout	Yes	No	Genital Herpes	Yes	No	Recent Weight Loss	Yes	No
Artificial Heart Valve	Yes	No	Glaucoma	Yes	No	Renal Dialysis	Yes	No
Artificial Joint	Yes	No	Hay fever	Yes	No	Rheumatism Fever	Yes	No
Asthma	Yes	No	Heart Attack/Failure	Yes	No	Rheumatism	Yes	No
Blood Disease	Yes	No	Heart Murmur	Yes	No	Scarlet Fever	Yes	No
Blood Transfusion	Yes	No	Heart Pace Maker	Yes	No	Shingles	Yes	No
Breathing Problem	Yes	No	Heart Trouble/Disease	Yes	No	Sickle Cell Disease	Yes	No
Bruise Easily	Yes	No	Hemophilia	Yes	No	Sinus Trouble	Yes	No
Cancer	Yes	No	Hepatitis A	Yes	No	Spina Bifida	Yes	No
Chemotherapy	Yes	No	Hepatitis B or C	Yes	No	Stomach/Intestinal Disease	Yes	No
Chest Pains	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Cold Sores/Fever Blisters	Yes	No	High Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Congenital Heart Disorder	Yes	No	Hives or Rash	Yes	No	Thyroid Disease	Yes	No
Convulsions	Yes	No	Hypoglycemia	Yes	No	Tonsillitis	Yes	No
Cortisone Medicine	Yes	No	Irregular Heartbeat	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No	Tumors or Growths	Yes	No
Drug Addiction	Yes	No	Leukemia	Yes	No	Ulcers	Yes	No
Easily Winded	Yes	No	Liver Disease	Yes	No	Venereal Disease	Yes	No
Emphysema	Yes	No	Low Blood Pressure	Yes	No	Yellow Jaundice	Yes	No
Epilepsy or Seizures	Yes	No	Lung Disease	Yes	No			
Excessive Bleeding	Yes	No	Mitral Valve Prolapse	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ **Date:** _____

Medical Health Reviewed by (Doctor): _____ **Date:** _____

DENTAL SERVICE AGREEMENT **CHART #**

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

ARTICLE 1. 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 WERE IMPROPERLY, NEGLIGLENTLY OR INCOMPLETELY RENDERED, WILL BE DETERMINED BY SUBMISSION TO ARBITRATION AS PROVIDED BY CALIFORNIA LAW, AND NOT BY A LAWSUIT OR RESORT TO COURT PROGRESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OR 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 THEIR USE OF ARBITRATION.

ARTICLE 2. In the event of any claim, demand, controversy or dispute the essential nature of which involves personal injury, malpractice or any tort, by Patient, his dependents, whether or not minors, heirs at law or personal representatives against Doctor or any of Doctor's officers, director, shareholders, agents, representatives, employees, successors in interests, assigns or associates agreeing in writing to be bound by the arbitration provisions of this agreement ("Affiliates"). THE DOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE 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 partied. In the event that the parties cannot agree upon a sole Arbitrator, each party shall pick an Arbitrator who is a licensed Dentist in California and the two Arbitrators shall pick a third Dentist proceeding under the rules of the American Arbitration Association. Not withstanding 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 is subject to this agreement may be intervened or joined.

ARTICLE 3. The prevailing party is any arbitration pursuant to this agreement shall be awarded all costs, including reasonable attorneys' fees and the Arbitrators' fees, in prosecuting or defending that claim in arbitration, but not to exceed $5,000 in amount. Furthermore, if any action is undertaken to set aside 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 petition a bond or cash surety in an amount equal to Five Hundred Dollars ($500) which shall provide security for attorneys' fees and costs in the event that the moving party shall not prevail.

ARTICLE 5. The agreement shall govern all future services rendered to Patient by Doctor and Doctor's Affiliates and Associates. Execution of this agreement is a precondition to the furnishing of services by Doctor, 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 by a written revocation signed by both parties.

ARTICLE 6. I Understand that each Doctor is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Doctors or corporate entity, other than the treating Doctor, is responsible for my treatment.

ARTICLE 7. Doctor hereby agrees to render dental care and service to Patient. Patient agrees to pay Doctor promptly upon rendering of a bill at the current prevailing rates, or to cooperate with Doctor in obtaining payment from third party payors.

ARTICLE 8. Except for the fact that Doctor has indicated professional services will not be rendered to Patient unless this agreement is executed Doctor has made no other representations or statements, oral or written, to induce Patient to execute this agreement.

ARTICLE 9. In the event that any provision of this agreement shall be void or unenforceable for any reason whatsoever, then such provisions 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 OF 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 COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____
Patient's Signature

_____
Patient's Agent or Representative

_____
Relationship to Patient

_____
Doctor

Date of Signing _____ **AM/PM**

INFORMED CONCENT FOR GENERAL DENTISTRY

Patient Name (First, Last): _____ Date of Birth: _____

1. **EXAMINATIONS AND X-RAYS**
   I understand that the initial visit may require radiographs to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.

   (Initial _____)

2. **DRUG, MEDICATION AND SEDATION**
   I have been informed and understand that antibiotics, analgesics and other medication can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased with the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given to me in the office for my care. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my Dentist of all medications I am currently taking.
   The written informed consent, in the case of a minor, shall include, but not be limited to, the following information: the administration and monitoring of anesthesia may vary depending on the type of procedure, the type of practitioner, the age and the health of the patient, and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for your child's anesthesia for his or her dental treatment and consult with your Dentist or Pediatrician as needed.

   (Initial _____)

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 may any/all changes and additions as necessary.

   (Initial _____)

4. **DENTAL PROPHYLAXIS (CLEANING)**
   I understand that treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

   (Initial _____)

5. **FILLINGS**
   I understand that a more extensive restoration than originally diagnosed may be required due to additional decay or unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common effect of a newly placed filling.

   (Initial _____)

6. **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, exposed sinuses, 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 bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that 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.

   (Initial _____)

7. **CROWNS, BRIDGES, VENEERS AND BONDING**
   a. 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 that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size and color) will be before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipate. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily

cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the brown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment to my delaying permanent cementation.

(Initial _____)

b. I am electing to use noble, high noble or ceramic instead of base metal in my crown and bridge restorations.

(Initial _____)

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that this fixed bridge or implant may not be a covered benefit under my insurance policy.

(Initial _____)

8. DENTURES – COMPLETE OR PARTIAL

I realize that fill or partial dentures are artificial, constructed or plastic, metal and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in new denture (including shape, fit, size, placement and color) will be the "teeth in wax" try-in visit. Immediate dentures may require several adjustments and relines permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that my dentures may require relining approximately three to twelve months after initial placement. I understand that failure to keep delivery appointments may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days, there will be additional charges.

(Initial _____)

9. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment, and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reason root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen a preserve through the tooth and understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that a tooth may be lost despite all efforts to save it.

(Initial _____)

10. PERIODONTAL TREATMENT

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.) Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products and follow other recommendations. I understand bleeding could las for several hours. Should it persist, particularly if it severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

(Initial _____)

11. IMPLANTS

I understand that no dentistry is permanent, and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting the artificial devices, and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is a slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be of a temporary or rarely permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointment and report as instructed by the treating dentist.

(Initial _____)

12. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide. Coffee. Tea and tobacco will stain teeth after treatment and are

to be avoided for at least 24 hours after treatment. I understand I may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching is approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment mean acceptance of risk.
Pregnant women are advised to consult with their physician before starting treatment.

(Initial _____)

13. **NITROUS OXIDE**

I elect to have nitrous oxide in conjunction with my dental treatment. I have informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initial _____)

14. **DENTAL BENEFITS**

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment.

(Initial _____)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist or corporate entity, other then the treating Dentist, is responsible for the dental treatment. I acknowledge the receipt od and understand post-operative instructions and have been given an appointment date to return.

Signature of Patient, Parent or Guardian: _____ **Date:** _____

Signature of Treating Dentist/Doctor _____ **Date:** _____

APPOINTMENT POLICIES/POLITICAS DE NOMBRAMIENTO

Date: _____

Patient Name: _____ DOB: _____

If for any reason you cannot keep your appointment, you must notify the office at least 24 hours in advance. If you fail to notify the office, there will be a mandatory charge of:

General Dentistry: $35
Oral Surgery: $100
Periodontics: $75
Orthodontics: $35
Endodontics: $75

We thank you in advance for your understanding.

SIGNATURE **DATE**

Si por alguna razón usted no puede mantener su cita, usted debe notificar a la oficina de al menos 24 horas de antelación. Si usted no notifica a la oficina, habrá un cargo obligatorio de:

Odontologia General: $35
Cirugia Oral: $100
Periodoncia: $75
Ortodoncia: $35
Endodoncia: $75

Le agradecemos do antemano su comprensión.

FIRMA **FECHA**

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET AND NOTICE OF PRIVACY PRACTICES

As of January 1, 2002, the Dental Board of California now requires that we distribute to our patients a copy of the Dental Materials Fact Sheet. In addition, the Health Insurance Portability and Accountability Act (HIPAA) require that patients be given a copy of our Notice of Privacy Practice.

If you would, please print and sign your name below acknowledging you have received these forms from this office.

1. A copy of the Dental Material Fact Sheet; and
2. Notice of Privacy Practices

_____
PRINT NAME OF PATIENT/PARENT/GUARDIAN

_____
SIGNATURE

_____
DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ **Individual refused to sign**
- □ **Communications barriers prohibited obtaining the acknowledgement**
- □ **An emergency situation prevented us from obtaining acknowledgment**
- □ **Other (Please Specify Below)**