

PATIENT REGISTRATION

ID: _____

Chart ID: _____

First Name: _____

Last Name: _____

Middle Initial: _____

Patient Is: Policy Holder

Preferred Name: _____

Responsible Party

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec.: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired

Emergency Contact: _____

Student Status: Full Time Part Time

Emergency Ph#: _____

Medicaid ID: _____ Pref. Dentist: _____

Relation to patient: _____

Employer ID: _____ Pref. Pharmacy: _____

Medical Physican : _____

Carrier ID: _____ Pref. Hyg.: _____

MD Phone Number: _____

Employer Name : _____

Employer Address : _____

Primary Insurance Information

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

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

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area 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 questions.

- 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 medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

Do you have, or have you had, any of the following?

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

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

Comments: _____

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 _____

**Anwaar Mansour DDS
Malek Mansour DDS, MAGD, PhD
16100 Sand Canyon Ave. #330
Irvine, Ca. 92618
(949) 585-1515**

FINANCIAL POLICY

Our practice is based on simple truth that if we satisfy & delight our patients they achieve the dental results they want and be more likely to tell others about their dental experience. Dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee perfect results.

The Dentist that you are seeing has adopted the following Financial Policy so that we can keep our costs down and still provide high quality dental care to you the patient.

* As a courtesy to our patients, we will call your insurance company to verify benefits. Ultimately, the patient is responsible for payment of all services provided by this Office. We will not be liable for any misinformation provided by the insurance company, and we recommend that the patient personally contact their insurance carrier if they should have any questions regarding their benefits.

* Payment for Services: Payment is due at the time of services. Cash, Check or Credit Card will be collected at the time of service.

* Secondary Insurance claims will be filed as a courtesy.

* A 50% deposit is required from those patients with dental insurance. Any balance owing after your insurance has paid will be billed to you. After 60 days, the accounts with no payment activity are subject to additional collection fees and interest charges of 1.5% per month or 18% per year will be assessed. If the account turns into collection, you will be responsible for any legal fees.

* Return checks are subject to a \$40.00 fee and any bank charges. The charges for rendered services and the return fee must be paid with cash or money order. Checks not immediately paid are subject to collection and interest fees.

***It is Office Policy that unless there is a 24 Hour Notice prior to cancellation of your appointment, a \$50.00 charge will be made.**

My signature below certifies that I have read and understand the terms of the Financial Policy and the 24-hour cancellation policy listed above. I understand I am responsible for all costs of the dental treatment regardless of insurance.

Signature of Patient (or guardian if minor)

Date

Print Name of Patient

DENTAL MASTERS
Malek Mansour, DDS, MAGD, PhD
Anwar Mansour, DDS
16100 Sand Canyon Ave, Suite 330
Irvine, CA 92618
(949) 585-1515 Fax (949) 585-1519

***Acknowledgement of Receipt of
Notice of Privacy Practices***

*You may refuse to sign this acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For office use only

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

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An Emergency situation prevented us from obtaining acknowledgement.
- Other(Please Specify):

DENTAL MASTERS
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16100 Sand Canyon Ave, Suite 330
Irvine, CA 92618
(949) 585-1515 Fax (949) 585-1519

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____

Social Security # : _____

Section B: To The Patient – Please Read The Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice at any time containing:
Contact Person: **Dr. Malek Mansour, DDS, MAGD, PhD**

Telephone: **(949) 585-1515** Fax: **(949) 585-1519**

Address: **16100 Sand Canyon Ave, Suite 330, Irvine, CA 92618**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the Consent will not affect any action we look in reliance on this Consent before we received your revocation and that we may decline to treat you or continue treating you if you revoke this Consent.

Signature

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing the Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following

Personal Representative's Name: _____

Relationship to Patient: _____

INFORMED CONSENT FOR DENTAL TREATMENT

1. DRUGS, MEDICATIONS

POSSIBLE COMPLICATIONS: I understand that antibiotics, analgesics, and other medications may cause adverse reactions, redness, swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, and possible death. Also, drowsiness and lack of coordination can be increased by the use of other drugs. I have been advised not to operate any vehicle or hazardous device while taking medications or until fully recovered from their effects. BENEFITS: Reduce pain, swelling, fever, and infections. CONSEQUENCES: Pain, swelling, fever, infections, and tooth loss. INITIALS _____

2. LOCAL ANESTHETICS

POSSIBLE COMPLICATIONS: I understand local anesthetics can cause prolonged persistent anesthesia, numbness, and or irritation to the injection site. BENEFITS: Avoidance of pain during treatments and procedures. CONSEQUENCES: Mild to severe pain during and after treatments. INITIALS _____

3. XRAYS

POSSIBLE COMPLICATIONS: I understand that the exposure to X-Ray radiation is minimal. BENEFITS: More complete diagnosis is available. CONSEQUENCES: Incomplete diagnosis and treatment plan. INITIALS _____

4. CLEANING, SCALING, AND HYGIENE

HYGIENE: I understand that the long-term success of treatment depends on my oral home care. CLEANING: POSSIBLE COMPLICATIONS: I understand that some teeth may be a little sensitive. BENEFITS: Protects my investment, the mouth looks nicer, simple stains are removed, and pleasant breath. CONSEQUENCES: Unhealthy teeth and gums. ALTERNATIVES: None. SCALING/PERIODONTICS: POSSIBLE COMPLICATIONS: I understand that I have a potentially serious condition causing gum inflammation leading to bone loss. This bone loss in turn can lead to the loss of my teeth and other physical problems. Sometimes treated teeth may need extraction. Some tooth and gum sensitivity is possible. Spaces between teeth and gums may be visible. Poor fillings may become loose. BENEFITS: Eliminates infection, helps arrest bone loss, and may help tighten teeth that have some mobility. CONSEQUENCES: Tooth loss. ALTERNATIVE: None. INITIALS _____

5. FILLINGS

POSSIBLE COMPLICATIONS: I understand the need for fillings, either silver (amalgam) or composites (resin) to replace tooth structure lost through decay. I understand that in time fillings will need to be replaced due to wear of the material. I understand that if the decay is very deep, the tooth may abscess after a filling is done. I understand that toxicity from silver (amalgam) fillings had been alleged, but is an acceptable procedure according to the ADA guidelines. Advantages and disadvantages of alternate materials have been explained to me. BENEFITS: Eliminates decay relieves pain, protects a sensitive surface, CONSEQUENCES: Root canal Therapy and a Crown. ALTERNATIVE TREATMENT: Tooth loss. INITIALS _____

6. ROOT CANAL THERAPY

POSSIBLE COMPLICATIONS: I understand the purpose of the root canal therapy. This therapy has been explained to me, as well as my alternative treatments. I understand that following the root canal therapy my tooth will become dry and brittle and must be protected against fracture by crown. I understand that either an undiagnosable root fracture or auxiliary canal means failure and extraction. Post treatment swelling around area for several days is possible. Infection can continue. Breakage of Root Canal instrument which may or may not be left in canal, per the Doctor's judgment or may require oral surgery to retrieve. Perforation of the canal with instruments, which may require an additional surgical treatment or result in premature loss of the tooth. BENEFITS: Eliminates the decay, relieves pain and saves the tooth. CONSEQUENCES: Continued infection and loss of tooth. ALTERNATIVE TREATMENT: Extraction. NOTE: If an open and medicate is done, I understand that this is not a permanent treatment. INITIALS _____

7. EXTRACTION

POSSIBLE COMPLICATIONS: I have been advised that if my condition persists without treatment, my present oral condition will worsen over time. I understand the POTENTIAL RISKS of oral surgery include, but are not limited to; post operative discomfort, swelling, dry socket, infection; and possible injury to adjacent teeth, crowns, and fillings. There may be a residual root fragment or bone spicules left when complete removal, would require extensive surgery and needless complications. I understand that sometimes after extraction there is a stiffness of facial or neck muscles, change in bite or TMJ joint difficulty. I understand that bad infections sometimes take a while to clear up. My jaw may be stiff or sore and difficult to open for a while and if the jawbone is weak it may fracture. BENEFITS: Helps to eliminate pain and infection. CONSEQUENCE: A general worsening of my present oral condition. Continued spread of infection, swelling, and increasing pain. In rare instances death can result. ALTERNATIVES: None. INITIALS _____

8. VENEERS OR BONDED FACINGS

POSSIBLE COMPLICATIONS: I understand that breakage can occur as with any porcelain product, resulting in a remake. The edges can stain after some time and need to be repaired. Veneers once placed are extremely difficult to remove. BENEFITS: They improve looks; are used to cover crooked, worn or broken teeth (primarily anteriors); can close spaces or gaps and are used to cover discolored teeth. CONSEQUENCES: None. ALTERNATIVES: Crowns. INITIALS _____

9. CROWNS (CAPS) AND BRIDGEWORK

POSSIBLE COMPLICATIONS: I understand that sometimes it is not possible to match the color of my natural teeth exactly with artificial teeth. Porcelain may fracture on the crown or bridge, necessitating repair. I understand that I may be wearing temporary crowns, which may come off easily and require recementation. 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 to my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation. It is also my responsibility to return for my permanent cementation within 30 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there I will be responsible for additional charges for remakes due to my delaying permanent cementation. Tooth may abscess under the crown requiring a root canal. New decay at the edges of the crown is possible. Irreversible pulp damage 5.7% when vital teeth prepared for a crown. BENEFITS: Improves appearances and protects weakened teeth. CONSEQUENCES: Tooth may fracture. ALTERNATIVES: Partial removable dentures. INITIALS _____

10. PARTIALS AND DENTURES

POSSIBLE COMPLICATIONS: Looseness, soreness, possible breakage and relining due to tissue shrinkage. There are necessary follow-up appointments for maintenance. Partials, clasps can wear on natural teeth, can rock or stress own teeth, the metal clasps are sometimes visible, decay can occur under the clasps if I do not maintain my oral hygiene and there is always some movement from the partial. BENEFITS: Less cost. CONSEQUENCES: Teeth move, food collects. ALTERNATIVES: Crown and bridges. INITIALS _____

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 which I have requested and authorized. My cooperation with recommendations and requests by the doctor is very important and lack of the same would result in less than optimum results and satisfaction. 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 is responsible for my dental treatment. If for any reason a conflict arises I will first present such conflict or disagreement to the dentist in order to resolve the problem.

I have read the above statements and have received a copy. My initials indicate that I have read and understand this consent document. I now give my consent to the attending dentist and/or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment.

I further agree to reimburse the attending dentist for all services rendered to me. I am aware that payment or my share of cost for these services is due in full at the time they are rendered. I further understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable in full at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% per month finance charge or 18% per year (APR) will be assessed. If the account turns into collection, I will be responsible for any legal fees.

Patient Name (Print)

Signature of Patient (or Authorized Guardian)

Date

Dentist

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical 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 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 any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any 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" shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, 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 of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration 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 thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or 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 issues 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 any 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 Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior 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.

Articles 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical 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 medical services

Patient's or patient representative's initials

If any provision 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 below, I acknowledge that I have received a copy,

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.

By: _____
Physician's or authorized Representatives Signature

By: _____
Patient's/Patient representative's signature Date

Print or Stamp Name of Physician/Association Name

By: _____
Print Patient's Name

By: _____
(If Representative, Print Name and Relationship to the patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in the Patients medical records.

During your first visit today we will take x-rays and you will receive a Comprehensive exam along with a periodontal evaluation. We are unable to guarantee cleaning in the first visit until the doctor has evaluated the condition of your gums. Studies show that 4 out of 5 American's have gum disease and if we find that you have this condition we will need to treat that first before a regular cleaning. If you would like more information regarding gum disease you may visit The American Academy of Periodontology at www.perio.org. Normally the first visit will take about an hour and a half we will go over all necessary treatment and answer any questions you may have regarding your treatment plan.

Once we have the doctor's diagnosis's we will go over necessary treatment and coverage details with your dental plan. During this time we will set a plan for your treatment and discuss financial options available. For example we except Visa, Master Card, Discover and American Express and have a few different financing plans available 6 and 12 months interest free or extended monthly payment plans 24-60 months with a low interest.

Prophy

(no bleeding & healthy gums)
Polishing of the teeth with light scaling.

Full Mouth Debridment

Removing heavy calculus and in some cases we may need to place medication.

Scaling and Root Planning (Deep Cleaning)

When you have pocket depths of 3mm and up we scale along the root surface of your teeth and place medication to kill the bacteria. There are different stages of periodontal disease and depending on the severity of your condition you may require further treatment other then scaling root planning.

Patient Signature

Date