



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

DOCTOR

DATE OF SIGNING

WELCOME TO DENTAL SPA OF WEST COVINA!

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

PATIENT INFORMATION:

Last Name First Name Age DOB SSN Male / Female

Home Address City, State, Zip (_____) Home Phone (_____) Cell Phone Email

Employer Name Address City, State, Zip (_____) Work Phone

PARENT/GUARDIAN INFORMATION:

Last Name First Name Age DOB SSN Male / Female

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:

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 Male / Female

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:

Last Name First Name Age DOB SSN Male / Female

Insurance Company (_____) Eligibility Phone Subscriber ID

Secondary Insured:

Last Name First Name Age DOB SSN Male / Female

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? _____
2. My last physical examination was on: _____ Yes No
3. Are you now under the care of a physician? Yes No
4. The name and address of my physician is: _____ Yes No
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: Yes No
 - 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 _____ Yes No
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: Yes No
 - 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?) _____ Yes No
16. Do you have, or had, any of the following diseases or problems? Yes No
 - 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: Yes No
 - 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



OFFICE POLICIES

Welcome to Dental Spa of West Covina! We are excited to have you as our lifelong patient! It is our 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 at least 48 hours in advance if you need to cancel, change, or reschedule your appointment. 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 not cancelled/rescheduled with 48 hour 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 appointment, if not, the appointment will be released and you will NOT be seen. If the appointment is cancelled without 5 days notice or the patient fails the appointment, \$100 of 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 prescribed. The treatment plan will show the ESTIMATED insurance portion and your copayment. Please note that the insurance portion is only an 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 paid 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.

If you choose to pay by check and your check is returned by your financial institution for ANY reason, you will be responsible for a \$30 service charge in addition to the amount of the returned check.

Should your account become delinquent for more than 60 days, a finance charge of \$50 or 5% per month will apply, whichever is greater. If your account should be referred to an attorney or collection agency, the undersigned shall be responsible for ALL additional fees incurred in the collection process.

PAYMENT OPTIONS

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

Cash Check Visa MasterCard Discover

We also offer promotional financing through:

CareCredit Springstone Financial

Patient Initials: _____



TERMS AND CONDITIONS

As a condition of treatment by Dental Spa of West Covina, 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 Dental Spa of West Covina, I agree to pay, therefore, the value of said services to Dental Spa of West Covina at the time services are rendered. I further agree that the value of said 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 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 my permission to Dental Spa of West Covina 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 _____