

Picasso Smiles DENTAL
COSMETIC & IMPLANT CENTER

REGISTRATION FORM HISTORY
Patient Information

Date _____

Name: _____ Date of Birth _____ SS #: _____

Home phone # () _____ Cell phone # () _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Driver's License # _____ State _____ Email Address: _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If College Student: Full time Part time Please send me special promotions: Yes No

How did you hear about us? Billboard Flyer Newspaper Website Facebook

I dreamt I should come here Referred by _____

Household Information or Responsible Party

Name: _____ Date of Birth _____ SS #: _____

Home phone # () _____ Cell phone # () _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Driver's License # _____ State _____ Email Address: _____

Insurance Information

Name of Insured: _____ Date of Birth _____ SS #: _____

Employer's Name _____ Employer's Phone () _____

Name of Primary Insurance Co. _____ Insurance Co. Phone () _____

Name of Secondary Insurance Co. _____ Insurance Co. Phone () _____

This information I have given is true and correct. I authorize release of any information relating to my dental treatment to any and all insurance carrier's that may pay benefits for claims submitted for my dental treatment including those whom I am responsible for.

I hereby authorize payment from my insurance carrier of the dental benefits otherwise payable to me directly to Picasso Smile I understand that I am responsible for all cost or dental treatment whether or not my insurance pays for my or whom I am responsible for.

Signed (Responsible Party/Patient or Parent if Minor)

Date

Signed (Insured Person)

Date

Picasso Smiles DENTAL
COSMETIC & IMPLANT CENTER

MEDICAL / DENTAL 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.

<p>Are you under a physician's care now? If yes, explain: _____ Have you ever been hospitalized or had a major operation? If yes, explain: _____ Have you ever had a serious head or neck injury? Are you taking any medication, pills, or drugs? If yes, explain: _____ Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonal or any other medications containing bisphosphonates? Are you on a special diet? Do you use tobacco? Do you use controlled substances?</p>	YES NO	CONT. High Blood Pressure High Cholesterol Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints Parathyroid Disease Psychiatric Care Yellow Jaundice Any serious illness not listed above?	YES NO	Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease	YES NO
PATIENT DENTAL HISTORY					
Reason for this visit _____ Date of last dental Visit _____ What was done? _____ Previous dentist name/location _____					
Circle all that you are concerned about/currently have:					
Tooth pain/ache Sensitivity To: Hot Cold Sweets Cavities Gum disease Pain to bite Broken teeth Broken Fillings Missing teeth Dark teeth Ugly teeth Crooked teeth Bad breath Clicking jaw Fear of dentists Loose teeth Spacing Grinding/clenching Jaw or face pain Headaches Want whiter teeth Want to save teeth Poor dentistry Want gentle dentist Dream teeth fall out Recession Cosmetic dentistry Snoring/Apnea Nothing Bleeding gums					
I am changing dentist because: Check any that apply _____ Recently moved into this area from _____ _____ Dr/staff personality / Communication problem _____ Inadequate care _____ Fee concern _____ I'm fleeing managed care / don't want a "list" dentist _____ To find a dentist team who understands my needs					
I have avoided dental care in the past because: _____ Fear of _____ _____ Time commitment _____ No perceived need _____ Financial commitment _____ Trust factor If you could change anything about your smile, what would you change?					
Are you interested in exploring: Check any that apply _____ Invisalign invisible orthodontic aligners _____ Bright smile and zoom _____ Info on helping snoring or sleep apnea in your home _____ Sedation Dentistry (taking a pill) options _____ Smile Makeover _____ Smile Analysis and Design _____ Why dental infections cause heart and other diseases					

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

PATIENT CONSENT FORM HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the term of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protect health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient name: _____

Relationship to Patient: _____

Signature: _____

DENTAL SERVICE ARBITRATION AGREEMENT

(The dentist whose name appears below) SHAYESTEH & SHAMS CULVER CITY DENTAL CORP agree to provide to the undersigned patient dental, surgical and related health care services in consideration for the payment on a fee for service basis.

ARTICLE I

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 or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE II

Said agreement for arbitration as provided in Article I above shall apply to any legal claim or civil action in connection with this dental service, including but not limited to disputes as to dental malpractice against this Picasso Smiles, its agents, representatives, employees, successors in interest and staff dentist of the dentist and the patient "whether or not a minor" his heirs-at-law, personal representatives and any claim in tort, contract or otherwise the other of demand for arbitration of any controversy, the parties to the controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after notice has been given, the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time of the date of the notice of the selection of the neutral arbitrator. All notices or other papers required to be served shall be served by US MAIL.

ARTICLE III

The Dentist named below agrees only to provide such services as in his opinion are reasonable, necessary and appropriate. Should patient for reasons personal to himself/herself refuse to accept the procedures, medicines or courses of treatment recommended by the dentist, and if the dentist believes that no professionally acceptable alternative exist, and after being so advised that patient still refuse to follow the recommended treatment or procedure, then the patient shall be given no further treatment and the dentist shall have no further responsibility to provide services specified herein for the condition under treatment.

ARTICLE IV

The execution of this Arbitration Agreement is not a precondition to the furnishing of service by the Picasso Smiles. This Arbitration Agreement may be rescinded by written notice from the Patient or Patient's representative to the Picasso Smiles within 30 days of signature and if no such notice is given, the agreement herein concerning arbitration shall be binding and compulsory. This Arbitration Agreement binds the parties and their heirs, representatives, executors, administrators, successors, and assigns.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Signature: _____
"Patient or Spouse or Parent"

Date: _____

Doctor: _____

Witness: _____

INSURANCE DISCLOSURES

As a courtesy to our insured patients Picasso Smiles Dental will accept assignment of your dental insurance toward your dental account under the following terms and conditions. Be assured that we will make every effort to estimate your benefits from the information provided to us by your insurance carrier.

I understand and accept that this is only an estimate and in the event of an underpayment or non payment from my insurance carrier, then I, the insured patient/responsible party will be responsible for the difference in monies of underpayment or payment in full if non payment. And clear any and all outstanding balances to my account.

Patient/Parent/Responsible Party Signature

Date

Furthermore:

(Please initial all agreements)

 I, the insured patient/responsible party accept full responsibility for my dental insurance carrier for any information they do or do not give to Picasso Smiles Dental when verifying dental benefits.

 I, the insured patient/responsible party understands and accept I am fully responsible for my account regardless of any underpayment or non payment from my insurance. This may be due in part or in whole to deductibles, co-payments, usual and customary fees, previously applied treatment, lack of coverage, or waiting period as governed by my insurance carrier.

 I, the insured patient/responsible party accepts full responsibility to follow up with any outstanding claims which my insurance carrier has not processed including cooperating with Picasso Smiles Dental in responding quickly to my insurance carrier in the event additional information is requested of me.

 I, the insured patient/responsible party understands that my account is due in its entire balance within 30 days regardless of payment or not payment made by my insurance carrier.

 I, the insured patient/responsible party have read and understand the terms and conditions and do not hold Picasso Smiles Dental responsible for any underpayment or non payment from my insurance carrier.

 I, the insured patient/responsible party understands that all disagreements on how my claims are paid or not paid are between me and my dental insurance carrier as I am the owner of the insurance policy and not Picasso Smiles Dental.

 If I, the insured patient/responsible party carry multiple insurances, will cooperate with Picasso Smiles Dental in the event that there is a conflict as to primary and secondary coverage.

I, the patient/responsible party accept full responsibility of my account balance regardless of insurance payments.

Patient/Parent/Responsible Party Signature

Date