CHEEMA
DENTAL & ORTHODONTICS

PATIENT INFORMATION (CONFIDENTIAL)

FIRST NAME:_____MI:_____

LAST:_____DATE:_____

ADDRESS:_____CITY:_____STATE_____ZIP_____

E-MAIL:_____CELL:_____HOME:_____

SSN# / TIN:_____BIRTHDATE:_____

CHECK APPROPRIATE BOX: ⬜ MINOR ⬜ SINGLE ⬜ MARRIED ⬜ DIVORCED ⬜ WIDOWED ⬜ SEPARATED

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____PHONE_____

RESPONSIBLE PARTY

NAME OF RESPONSIBLE PARTY:_____RELATIONSHIP TO PATIENT:_____

ADDRESS:_____HOME PHONE:_____

DRIVER LICENSE#:_____BIRTHDATE:_____SSN/TIN:_____

EMPLOYER:_____WORK PHONE:_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ⬜ YES ⬜ NO

INSURANCE INFORMATION

NAME OF INSURED:_____RELATIONSHIP TO PATIENT:_____

BIRTHDATE_____SSN/TIN:_____DATE EMPLOYED:_____

NAME OF EMPLOYER:_____UNION OR LOCAL#_____WORK PHONE_____

WORK ADDRESS:_____CITY:_____STATE_____ZIP_____

INSURANCE CO.:_____ TEL#:_____GROUP#:_____ID#:_____

COLLEGE STUDENT? ⬜ F/T ⬜ P/T, NAME OF SCHOOL:_____CITY_____

SPOUSE NAME_____EMPLOYER_____WORK #_____

DO YOU HAVE A SECONDARY INSURANCE? ⬜ YES ⬜ NOIF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED:_____RELATIONSHIP TO PATIENT:_____

BIRTHDATE_____SSN/TIN:_____DATE EMPLOYED:_____

NAME OF EMPLOYER:_____UNION OR LOCAL#_____WORK PHONE_____

INSURANCE CO.:_____ TEL#:_____GROUP#:_____ID#:_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN:_____**DATE:**_____

Dental History

Reason for this visit_____
Are you currently in pain_____
When was your last dental visit _____ What was done then _____
How often did you visit the dentist before then _____
Previous dentist (Name and Location) _____
Have you had a complete series of dental films (x-rays) taken, when, where _____
How often do you brush your teeth _____ How often do you floss your teeth _____
Is your drinking water fluoridated _____
Do you require antibiotics before dental treatment? _____

	YES	NO		YES	NO
Do your gums bleed while brushing Or flossing?	☐	☐	Do you bite your lips or cheeks frequently?	☐	☐
Are your teeth sensitive to hot or cold Liquids/Foods?	☐	☐	Have you noticed any loosening of Teeth?	☐	☐
Are your teeth sensitive to sweet or sour Liquids/Foods?	☐	☐	Does food tend to become caught between your teeth?	☐	☐
Do you feel pain to any of your teeth? . . .	☐	☐	Have you ever had PERIODONTAL treatment (gums)?	☐	☐
Do you have any sores or lumps in or Near your mouth?	☐	☐	Ever worn a bite plate or other appliance? . .	☐	☐
Have you had any head, neck, or jaw Injuries?	☐	☐	Have you ever had any difficult extractions in the past?	☐	☐
Have you ever experience any of the Following problems in your jaw?			Have you ever had any prolonged bleeding following extractions?	☐	☐
Clicking	☐	☐	Do you wear dentures or partials?	☐	☐
Pain (Joint, Ear, Side of Face)?	☐	☐	If yes, Date of placement_____		
Difficulty in opening or closing?	☐	☐	Have you ever received Oral Hygiene Instructions regarding the care of		
Difficulty in chewing?	☐	☐	your teeth and gums?	☐	☐
Do you have frequent headaches?	☐	☐	Do you have a prosthetic Joint / Implant? . .	☐	☐
Do you clench or grind your teeth?	☐	☐	If so, describe where_____		
Do you have any mobility in your teeth? . . .	☐	☐			

If you could change anything about your smile, what would you change?

_____

AUTHORIZATION AND RELEASE

I CERTIFIED 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 COULD BE DANGEROUS TO MY HEALTH. I AUTHORIZED CHEEMA DENTAL CORPORATION 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 PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZED AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENTS OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X_____ _____
Signature of patient/or guardian if minor Date

_____

Doctor's comments

_____

_____

X_____ _____
Doctor's Signature Date

PATIENT MEDICAL HISTORY FORM **PATIENT'S NAME:** _____ **DATE OF BIRTH:** _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATIONS THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1) Are you in Good Health?	□	□
Height _____ Weight _____		
2) Have there been any changes in your health within the past year?	□	□
3) Date of your last Physical Exam: _____		
4) Physician's Name _____		
Address _____	□	□
Phone Number (_____)_____		
5) Are you now under the care of a physician?		
6) Have you been hospitalized for any Surgical Operations or Serious Illness	□	□
Please explain _____		
7) Are you taking any Medicine (s)?	□	□
Including non-prescription Medicine. If Yes, list the medicine (s) you are taking:_____		
8) Are you taking *Bisphosphonate* Medication (s)?	□	□
9) Have you had any Abnormal Bleeding?	□	□
10) Do you Bruise easily?	□	□
11) Have you ever required a Blood Transfusion?	□	□
12) Have you had a recent weight loss?	□	□
13) Have you ever taken Fen-Phen / Redux?	□	□
14) Do you use tobacco?	□	□
15) Do you or have you used Controlled Substances?	□	□
16) Are you wearing contact lenses?	□	□
17) Do you have a persistent cough or throat clearing not associated with a known Illness (lasting more than 3 weeks)?	□	□
18) Do you have any disease, condition or problems not listed above that I should know about? _____	□	□

WOMEN ONLY:

Are you pregnant or think you may be Pregnant? Week #_____	□	□
Are you nursing?	□	□
Are you taking birth control pills?	□	□

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
Local Anesthetics like Novocaine	□	□
Penicillin or other Antibiotics	□	□
Codeine	□	□
Sulfa Drugs	□	□
Barbiturates, Sedatives or Sleeping Pills	□	□
Aspirin	□	□
Iodine	□	□
Any Metals (E.G., Nickel, Mercury, ETC.)	□	□
Latex / Rubber	□	□
Other (please list) _____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
AIDS or HIV infection	□	□
Allergies	□	□
Anemia	□	□
Arthritis or Rheumatism	□	□
Asthma	□	□
Back Problems	□	□
Blood Pressure High	□	□
Blood Pressure Low	□	□
Chemical Dependency	□	□
Chemotherapy (Cancer / Leukemia)	□	□
Chest Pain	□	□
Cold Sores or Fever Blisters	□	□
Cortisone Treatment	□	□
Cough that produces Blood	□	□
Cough Persistently	□	□
Diabetes	□	□
Eating Disorders	□	□
Epilepsy or Seizures	□	□
Fainting or Dizzy spells	□	□
Glaucoma	□	□
Hay Fever	□	□
Heart Congenital Problems	□	□
Heart Defect or Heart Murmur	□	□
Heart Surgery	□	□
Heart Trouble, Heart Attack, or Angina	□	□
Hepatitis, Jaundice, or Liver Disease	□	□
Herpes	□	□
Hives or Skin rash	□	□
Hypoglycemia	□	□
Joint Replacement or Implant	□	□
Kidney Trouble	□	□
Liver Disease	□	□
Lung or Breathing Problems	□	□
Mental Health Care	□	□
Mitral Valve Prolapse	□	□
Nervousness	□	□
Other: _____	□	□
Pacemaker	□	□
Rheumatic Heart Disease or Rheumatic Fever	□	□
Scarlet Fever	□	□
Sexually Transmitted Disease	□	□
Shortness of Breath	□	□
Sinus Trouble	□	□
Snoring / Sleep Apnea	□	□
Stomach Ulcer	□	□
Stroke	□	□
Swelling of Feet, Ankles, Hands	□	□
Thyroid Problems	□	□
Tonsillitis	□	□
Tuberculosis	□	□
Tumors	□	□

OFFICE POLICIES

Patient Name (Print) **Date**

Welcome to Cheema Dental Corporation. We would like you to know that you are in great hands. We will strive to provide you with the best dental services that we possibly can.
Please understand that in order to do this we must follow these office policies:

REGARDING APPOINTMENTS:

- Excessive failed or canceled appointments. We ask that you let us know 24 hours in advance if an appointment has to be rescheduled or canceled. Less than 24-hour notice will result in a $35.00 charge to your account. This policy is not meant to make an inconvenience for any of our patients; this is just to keep appointment times available for all other patients including emergencies.

Initials: _____

INSURANCE DISCLAIMER:

- **Insurance** claims will be processed and billed at the UCR rate. Insurance quotes are only an estimate and it is not a guarantee of payment by the insurance carrier.
- **Insurance** eligibility must remain active for the entire duration of the dental treatment for the benefits to be payable. Please remember that your dental plan is considered a method of payment for services rendered. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. The Patient/Guarantor is responsible to pay any deductible amount, co-insurance or any other balances of treatment not paid by the Dental Insurance Carrier.
- If for any reason the insurance estimated amount is not paid by your insurance carrier, it becomes your responsibility.
- This signature below on file is my authorization for the release of information necessary to process my dental claim(s). I hereby authorize payments to Cheema Dental Corporation.

Initials: _____

LABORATORY CASES:

- Dental treatment that requires laboratory work is not returnable or refundable. Patients/Guardian are responsible for up to 100% of the cost for fixed or removable Prosthodontics even if you do not return to the office for the final delivery of the dental prosthetic/appliances. All lab appliances must be delivered within 30 days from start date. Failure to receive your lab case appliance/prosthetic within 30 day will result in additional charges.

Initials: _____

ADDITIONAL CHARGES:

- There will be a $25.00 charge for any returned check.
- Treatment may sometimes take longer due to circumstances beyond the control of the patient or the dentist. In that event, the original treatment fee will be honored. However, if treatment is extended due to the patient's failure to follow instructions or failure to keep scheduled appointments, an additional fee will be charged.
- If any payment is late, you will be charged 1.500% of the installment, or at least $39
- If the balance becomes 60 days or more overdue, our office reserves the right to interrupt or discontinue dental treatment and/or send your account to an attorney for collections. In the event that your account is sent to an outside collection agency or by legal proceedings, the undersigned will be responsible for all the costs and fees, including reasonable attorney's fees, court costs, accrued interests and all other costs of collection incurred.
- Any discounts will be rescinded if sent to collections.
- **If your account becomes delinquent ALL discounts will be revoked.**
- In addition, fees are subject to change if work is not initiated and completed in a timely manner.

Initials: _____

Retention of Documents Relating to Your Care and Agreement. By signing this, you understand and agree that it is our policy to scan original documents and store the documents in an electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed from the electronic form, has the same force and effect as the original document.

Signature of Patient/Legal Guardian Relationship to patient

ARBITRATION

Arbitration is the final process for the resolution of any dispute or controversy between a patient, or a personal representative of the patient, as the case may be, and **Cheema Dental Corporation** concerning the quality of patient services provided to the patient under this agreement for any dispute or controversy concerning the construction, interpretation, performance or breach of this agreement. By entering into this agreement, the patient agrees that such disputes shall be submitted to binding arbitration under the appropriate rules of the American Arbitration Association (AAA).

I. Patient understands and agrees that any and all disputes between patient and **Cheema Dental Corporation** or its providers shall be resolved by submission to binding arbitration conducted by the American Arbitration Association (AAA). Such Disputes or controversies include, but are not limited to, complaints concerning the quality, necessity or outcome of services provided pursuant to this Informed Consent Form, as well as the construction, interpretation, performance or breach of the terms of this Informed Consent Form.

II. The patient further recognizes that by consenting to binding arbitration, the patient is giving up the right to have such disputes decided in a court of law and/or before a jury. A declaration of a court or other tribunal of competent jurisdiction that any portion of this agreement to arbitrate is void or unenforceable shall not render any other provision hereof void or unenforceable. **Initials:** _____

INITIATION OF ARBITRATION

Arbitration can be initiated by filing a demand for arbitration with the AAA, located at 225 Bush Street, 18th Floor, San Francisco, CA 94104-4207, telephone number (415) 981-3901. A demand form may be obtained from the AAA.

Initials: _____

COSTS

In all arbitration matters submitted to the AAA, the party initiating demand for the arbitration shall advance all administrative fees connected therewith. If the patient prevails in arbitration, the patient may be entitled to reimbursement of costs including reasonable attorney's fees incurred in connection with the arbitration proceedings. Any such award of cost shall be made at the discretion of the arbitrator.

Initials: _____

LOCATION

Arbitration proceedings shall occur in the county where the patient's treatment was performed, unless all parties to the arbitration otherwise agree in writing.

Initials: _____

FORM OF DECISION

The parties agree that the arbitrators shall issue a written opinion. The award of the arbitrators shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition of enforcement of said award. The arbitrator's award shall be accompanied by a written decision explaining the facts and reasons upon which the award is based, including the findings of fact and conclusions of law made and reached by the arbitrator.

Initials: _____

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth), bone and tissues, as explained above. The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me. I also authorize the operating Dentist and Assistants to perform any other procedure, which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation. I know that the practice of Dentistry and surgery 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 treatment, which I have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues, (Paresthesia), fractured jaw, Temporomandibular Joint (TMJ) Complications, which could cause localized and systemic pain requiring future treatments including joint surgery, etc., have been clearly explained to me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT, INCLUDING THE OPPOSITE SIDE OF THIS DOCUMENT, AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME. I UNDERSTAND THESE DENTAL SERVICES ARE PROVIDED WITHOUT DISCRIMINATION BASED ON RACE, RELIGION. COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Signature: _____ Relationship: _____ Date: _____

Hipaa

Patient acknowledgment of receipt of 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 (HIPAA) requires effective April 14, 2003 that the patients be given a copy of our Notice to Privacy Practice.

I_____, acknowledge that i have received a Notice of Privacy Practices from Cheema Dental.

Signature:_____
Date:_____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name:_____

Relationship to Individual:_____

Signature.
I attest that the above information is correct.

Signature:_____ Date:_____

Print Name:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE