INFORMED CONSENT - OFFICE POLICY

I hereby request and authorize the Dentists and their staff to perform dental work or treatment upon me for the purpose of improving my dental health, including the healthand/or appearance of my teeth, gums, and mouth. I understand that results cannot be guaranteed. I understand that it is my responsibility to inform the Dentist if I am having problems during or after dental treatment so as to allow him/her to help minimize any problems. I have been informed regarding the following common dental procedures and office policies:

1. **DRUGS AND MEDICATIONS** may cause reactions including, but not limited to, itching, swelling, pain, fever, achiness, vomiting, stomach upset, drowsiness, dizziness, rapid heart rate. Rarely, anaphylactic shock (severe allergic reaction) may occur.
2. **LOCAL ANESTHETICS** may cause itching, pain, swelling, fever, vomiting, dizziness, rapid heart rate, stomach upset, drowsiness, muscle spasm, internal bleeding ("black and blue" areas) in the lip, cheek or jaw, prolonged anesthesia (numbness) or paresthesia (tingling) in the lip, cheek, jaw or tongue, infection, muscle spasms. Rarely, anaphylactic shock (severe allergic reaction) may occur.
3. **FILLINGS** may cause mild tooth or gum sensitivity, which usually subsides in a few days or weeks. Rarely, sensitivity may persist or worsen, and may cause the need for root canal treatment. Also on occasion, the bite may become uncomfortable and may need adjustment.
4. **CROWNS (CAPS) AND BRIDGES** may cause mild tooth or gum sensitivity, which usually subsides in a few days or weeks. Rarely, sensitivity may persist or worsen, and may cause the need for root canal treatment. It is not possible to match the color of natural teeth perfectly. Temporary crowns may loosen or come off, and it is important to have them recemented as soon as possible, and to avoid sticky or hard foods. Occasionally the bite may become uncomfortable and require adjustment of opposing teeth..
5. **PERIODONTAL (GUM) TREATMENT** may cause tooth or gum sensitivity, which usually subsides in a few days. Rarely, sensitivity may persist or worsen, or there may be itching, pain, swelling, infection, anesthesia (numbness), paresthesia (tingling)or internal bleeding ("black and blue" areas) in the lip, cheek, jaw or tongue. Periodontal treatment is cannot be guaranteed.
6. **EXTRACTIONS (TOOTH REMOVAL)** occasionally may cause severe pain, infection, swelling, fever, spread of infection, anesthesia (numbness), paresthesia (tingling) or internal bleeding ("black and blue" areas) in the lip, cheek, jaw or tongue, muscle spasm, "dry socket", bone (jaw) fracture, tooth fracture, fracture or loss of fillings, crowns and bridges, and increased difficulty with dentures (including increased looseness and denture irritation).
7. **ROOT CANAL TREATMENT (RCT)** occasionally may lead to pain, itching, swelling, fever, infection, anesthesia (numbness), paresthesia (tingling) or internal bleeding ("black and blue" areas) in the lip, cheek or jaw, tooth fracture, or tooth loss. Although RCT is usually successful, there can be no guarantee that a tooth will be saved. Also, after RCT the tooth must be restored with a filling or crown, at extra cost. Success cannot be guaranteed.
8. **DENTAL WORK TAKES TIME,** and may requires more time and/or office visits than originally planned.
9. **CHANGES IN THE TREATMENT PLAN** are sometimes necessary. This may affect the overall cost of treatment and that of individual procedures, and it may alter the time required to complete treatment. Any estimate of treatment cost is based on the completion of all of the treatment included in the plan. Any alteration of the plan may affect the cost of other items on the plan.
10. **X-RAYS** are a necessary adjunct to diagnosis and treatment. We make every effort to minimize radiation , and we believe that the exposure from dental X-rays is nil.Pregnantwomen and anyone concerned about radiation may wish to consult their physician prior to taking X-rays.
11. **DENTURES AND PARTIAL DENTURES, new, repaired, relined or adjusted, can not be guaranteed regarding comfort,** fit, function or cosmetics. Any denture procedure may require numerous adjustments, and denture adhesive may be needed.

GENERAL OFFICE POLICIES:

PAYMENT IN FULL IS REQUIRED FOR ALL SERVICES AT THE TIME OF APPOINTMENT, unless prior written arrangements have been made. Please familiarize yourself with your dental insurance or dental plan (HMO).
Dental insurance and dental plan eligibility and payment of benefits are the responsibility of the patient.
PLEASE: Let us know of any changes regarding your dental insurance or dental plan (HMO) since your last visit.
There will be an additional $10.00 monthly fee charged if billing is requested or required, and an additional 1%/mo. service charge on all balances due over 30 days.
We are pleased to accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and CARECREDIT for all payments.
There may be a 15% service charge (minimum $ 35.00) for returned checks and credit card reversals.
PLEASE: NO SMOKING, FOOD OR DRINK IN THE OFFICE.
PLEASE: CELL PHONES MAY ONLY BE USED IN THE WAITING ROOM.
PLEASE: BE ON TIME. If you are more than 15 minutes late there may be a late fee and/or we may not be able to complete all of the work planned for your appointment. The amount of this fee may be $20-$200 or more.
There is normally a charge for missed appointments without 48 hours (2 business days) notice. Depending on the appointment type and length, this charge may be $20-$200 or more.
Home care products may be returned within 24 hours of purchase, if unopened. There is a 15% restocking fee.
PLEASE: LET US KNOW OF ANY CHANGES REGARDING YOUR MEDICAL HISTORY ON EACH VISIT.

I acknowledge that no guarantee or assurance can be made regarding any dental work or treatment.
I hereby authorize the release of my dental records to my insurance company, dental plan, or other health care providers, as deemed necessary by the Dentist and/or Staff.
I certify that I have received a copy of the Dental Materials Fact Sheet (Calif. Board of Dental Examiners).
I certify that I have received a copy of Dental Records Are Confidential (HIPPA).
I certify that I have read the above and understand it, and I hereby request and authorize the Dentist and Staff to proceed with treatment.

Signature____ Date_______________ STAFF________

MEDICAL HISTORY

Date ________________

Patient's Name ________________

	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
Women: Are you PREGNANT?	☐	☐
Women: Are you currently taking birth control pills	☐	☐
Do you SMOKE?	☐	☐
Have you been a patient in a hospital in the past 5 years?	☐	☐

For What? ________________

Reason: ________________

What MEDICATIONS are you currently taking? ________________

List any allergies to medications ________________

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
Heart Disease or Attack	☐	☐	Hepatitis A (infectious)	☐	☐	Bruise Easily	☐	☐	Cosmetic Surgery	☐	☐
Angina Pectoris	☐	☐	Hepatitis B (serum)	☐	☐	Emphysema	☐	☐	Alcoholism	☐	☐
High Blood Pressure	☐	☐	Liver Disease	☐	☐	Tuberculosis (TB)	☐	☐	Chemotherapy	☐	☐
Heart Murmur	☐	☐	Blood Transfusion	☐	☐	Asthma	☐	☐	Glaucoma	☐	☐
Rheumatic Fever	☐	☐	Drug Addiction	☐	☐	Hay Fever	☐	☐	Kidney Trouble	☐	☐
Congenital Heart Lesions	☐	☐	Hemophilia	☐	☐	Sinus Trouble	☐	☐	Stroke	☐	☐
Mitral Valve Prolapse	☐	☐	Fever Blisters	☐	☐	Allergies or Hives	☐	☐	Anemia	☐	☐
Artificial Heart Valve	☐	☐	Epilepsy or Seizures	☐	☐	Diabetes	☐	☐	Arthritis	☐	☐
Heart Pacemaker	☐	☐	Nervousness	☐	☐	Thyroid Disease	☐	☐	Pain in Jaw Joints (TMJ)	☐	☐
Heart Surgery	☐	☐	Psychiatric Treatment	☐	☐	Radiation Treatment	☐	☐	Venereal Disease (Syphilis, Gonorrhea)	☐	☐
Artificial Joints (Hip, Knee)	☐	☐	Bleeding or clotting disorders	☐	☐	X-Ray Treatment	☐	☐	Allergic to Latex	☐	☐
H.I.V. Positive/A.I.D.S.	☐	☐	Herpes (Cold Sores)	☐	☐	Allergies	☐	☐			
Ever Taken Phen-Phen	☐	☐	Bleeding Problems	☐	☐	If YES, What?					

M.D. NAME

PHONE :

Patient Signature ________________ Staff Review ________________

HEALTH HISTORY UPDATE Date: ________

Current Medications: ________________

Health Changes: ________________

Patient Signature: ________________ Staff Review ________________

HEALTH HISTORY UPDATE Date: ________

Current Medications: ________________

Health Changes: ________________

Patient Signature: ________________ Staff Review ________________

HEALTH HISTORY UPDATE Date: ________

Current Medications: ________________

Health Changes: ________________

Patient Signature: ________________ Staff Review ________________

HEALTH HISTORY UPDATE Date: ________

Current Medications: ________________

Health Changes: ________________

Patient Signature: ________________ Staff Review ________________

HEALTH HISTORY UPDATE Date: ________

Current Medications: ________________

Health Changes: ________________

Patient Signature: ________________ Staff Review ________________

DENTIST PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to dental malpractice, that is as to whether any dental service rendered under this contract were unnecessary or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit to 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 an such disputes decided in a court of law before the 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 to relate to treatment or service provided by the dentist 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" herein 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 dentist, and the dentist's partners, associates, association, corporation or partnership, and the employees, agents, and estates to any of the 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 dentist 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 demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rate share of the expense and fees of the neutral, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees on witness fees, or other expense incurred by a party for such party' own benefits. 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 issue 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 with this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 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 Procedures.

Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken with prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same, incident, transaction or related circumstance shall be arbitrated in one proceeding. A claim 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 stature 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.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the dentist within 30 days of signature. It is the intent of this agreement to apply to all dental services rendered anytime for any condition.

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 to any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

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.
SEE ARTICLE 1 OF THIS CONTRACT.

By: ______________________________
Dentist's or Authorized Representative's Signature (Date)

By: ______________________________
Patient or Patient Representative's Signature (Date)

EDWARD L. ROSEN, D.D.S AND ASSOCIATES

By: ______________________________
Print Patient's Name

____
(If Representative, Print Name and Relationship to Patient

HEALTH HISTORY & REGISTRATION

TODAY'S DATE ________

Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name ______________________ Date ______________ Patient No. ________
First MI Last

Address ______________ City ______________ State ______ Zip ________

Birthdate ______________ Home phone # ______________ Work phone # ________

Social Security Number ______________ Cell/Pager # ________

Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Your or your parent's employer ______________ Occupation ________

Business Address ______________ City ______________ State ______ Zip ________

Spouse's or parent's name ______________ Workplace ______________ Work phone # ________

Whom may we thank for referring you to us? ________

Responsible Party

Name of person responsible for this account? ________

Relationship to patient ______________ Phone # ________

Address ______________ City ______________ State ______ Zip ________

Name of employer ______________ Work phone # ________

PRIMARY DENTAL INSURANCE INFORMATION	SECONDARY DENTAL INSURANCE INFORMATION
Insured's Name ________ Birthdate ________	Insured's Name ________ Birthdate ________
Insurance Co. Address ________	Insurance Co. Address ________
Insured's Employer ________ Phone ________	Insured's Employer ________ Phone ________
Insured's Soc. Sec. # ________ Group # ____ Emp # ____	Insured's Soc. Sec. # ________ Group # ____ Emp # ____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

NAME ______________ ADDRESS ________

CITY ______________ STATE ______ PHONE ______________ Relationship ________

DENTAL HISTORY

HOW LONG SINCE you have seen a Dentist? ________ Last COMPLETE Dental Exam, Date: ________

Last FULL MOUTH X-RAYS, DATE: ________ Last PROPHYLAXIS (Teeth Cleaning) ________

Are you have problems now? ________ WHAT? ________

INSURANCE CONSENT	CONSENT
I hereby authorize payment directly to Dr. Rosen of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization.	I hereby authorize release of any information relating to any insurance claim, and I authorize Dr. Rosen and staff to sign insurance forms on my behalf.
Signed (Insured person or parent of minor) Date	Signed (Insured person or parent of minor) Date

The undersigned hereby authorized the Doctor to take the X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental ends. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge and interest will be added to any overdue balance, and I will be responsible for any and all costs for collection of this balance.

PATIENT Signature ______________ Date: ______________ DENTIST Signature ________

****There will be a charge for all missed appointments without 48 hour notice****

ANNOUNCING THE MOST

SIGNIFICANT ADVANCEMENT IN 9,000 YEARS OF DENTISTRY.

TAKE THIS SIMPLE QUIZ TO LEARN HOW LUMINEERS WILL DRAMATICALLY

IMPROVE YOUR SMILE PAINLESSLY.

LUMINEERS®
BY CERINATE

PERMANENT, PLEASANT, PAINLESS™

SMILE EVALUATION QUIZ

Name: ______________________________

If you could improve your smile in a permanent, painless way, would you?

If you answer yes to any of the following questions, talk to your dentist about how you can improve your smile with the no shots, no pain and no drilling technique from LUMINEERS® BY CERINATE®.

1 Do you like the appearance of your teeth? ☐ Yes ☐ No

2 Are your teeth all in alignment (straight)? ☐ Yes ☐ No

3 Do you have spaces? ☐ Yes ☐ No

4 Do you like the color of your teeth? ☐ Yes ☐ No

5 Do you wish your teeth were whiter? ☐ Yes ☐ No

6 Are your teeth chipped? ☐ Yes ☐ No

7 Are your teeth protruding? ☐ Yes ☐ No

8 Are your teeth hidden? ☐ Yes ☐ No

9 Are your teeth wearing on the biting surfaces? ☐ Yes ☐ No

10 Are there old crowns, bridges, or fillings you don't like looking at? ☐ Yes ☐ No

11 What would you like your smile to look like? ______________

EVERYONE NOTICES YOUR SMILE.
Improve your self-image by having the smile you want with LUMINEERS® BY CERINATE.®
Ask your dentist.

LUMINEERS
BY CERINATE®

PERMANENT, PLEASANT, PAINLESS™

INFORMATION TO OUR PATIENTS

Our mission is to deliver the finest, most cost effective dental care available today. Following diagnosis the doctor will discuss with you our plan for treatment. We will also discuss the cost of today's and future treatments. Payment for all services is due at the time of treatment. Because your dental plan may not cover the entire cost of your treatment, we offer several alternative payment options for your convenience.

PAYMENT OPTIONS

1. Cash or Check

2. MasterCard or Visa

3. Monthly Payment Plan - The monthly payment is a separate line of credit for dental care only. It does not require payment now, nor the use of your bank credit cards, leaving them free for non-healthcare purchases and emergencies. It does not affect the balance of your other credit cards, and there are no annual fees. Monthly payments can be as low as 3% of your outstanding balance. For example:

Balance	Monthly Payment	Balance	Monthly Payment
$ 500.00	$ 15.00	$2,000.00	$ 60.00
$1,000.00	$ 30.00	$4,000.00	$120.00

Please indicate below the payment option you wish:

[ ] **Cash or Check**

[ ] **Visa or MasterCard**

[ ] **Monthly Payment Plan -** If you choose this option, we will help you complete the simple application, and processing will only take a few minutes.

Signature of Patient/Responsible Party

Date

7/97