

Personal Information

Last Name		First Name		M.I.	Preferred Name
Date of Birth	Social Security Number	Gender (Check) <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Child <input type="checkbox"/> Other	
Street Address					Unit/Apt. Number
City		State	Zip Code	E-mail Address	
Home Phone	Work Phone	Cell Phone		Best time to call?	
May we contact you via SMS text message regarding appointments and other information?					<input type="checkbox"/> Yes <input type="checkbox"/> No

Emergency Contact

If possible, please list an emergency contact that does not reside with you.

Name		Relationship	Telephone Number		
Address		City	State	Zip Code	

Referral Information

How did you hear about our office? (Check One):

- Insurance Company
 Newspaper Ad
 Internet Search
 Other: _____
 Referred by a Doctor, Dentist, or other Health Professional (Please provide appropriate information below):

Doctor's Name	City	Telephone Number
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Referred by another Patient (Please provide appropriate information below):

Last Name	First Name	Telephone Number
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Dental History

- Do you have dental exams on a regular basis? Yes No
- Do you think you have active gum decay or disease? Yes No
- On a regular basis, I... Brush Floss Brush & Floss Neither
- Do your gums ever bleed? Yes No
- Do you like your smile? Yes No
- Do you have any loose teeth? Yes No
- Do you ever have clicking, popping or discomfort in your jaw? Yes No
- Do you ever brux or grind your teeth? Yes No
- Do you smoke cigarettes/cigars and/or chew tobacco? Yes No
- Any sores or growths in your mouth? Yes No
- Do you wish to speak privately with the dentist about any issues and/or problems? Yes No
- Name of your previous/current dentist (optional): Name: _____ Phone: _____
- If known, please indicate the date of your last full-mouth X-Ray series (or Panoramic X-Ray) Date: _____

Medical History

Y	N		Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker *
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Growths	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Phen-Phen
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve *	<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy—Due Date: _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment (Cancer)
<input type="checkbox"/>	<input type="checkbox"/>	Bacterial Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur *	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery *	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B & C	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure (Hypotension)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse *	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

* May require prescribed medications prior to treatment by Dentist/Medical Doctor

Do you have any allergies to medications and/or materials? (If yes, check those that apply) Yes No
 Aspirin Penicillin Codeine Acrylic Metal Latex OTHER: _____

Have you ever had any serious illness that was NOT listed above? Yes No

If Yes, please explain: _____

Have you ever had any complications following dental treatment? Yes No

If Yes, please explain: _____

Have you ever been admitted to a hospital, had a major operation, or needed emergency medical care in the last two years? Yes No

If Yes, please explain: _____

Have you ever had a serious injury to your head or neck? Yes No

If Yes, please explain: _____

Are you currently taking any prescription or over-the-counter (OTC) medications? Yes No

If Yes, please explain & list your meds: _____

Are you currently using BISPSPHONATE medication? (Fosamax, Actonel, Boniva, or IV Bisphosphonates) Yes No

If Yes, please explain: _____

Are you currently under the care of a physician? Yes No

If yes, please list name & phone number: _____

WOMEN { Are you currently pregnant or trying to get pregnant? Yes No
 Are you currently nursing or planning to nurse after giving birth? Yes No
 Are you currently taking oral contraceptives? Yes No

Certification Of Information

To the best of my knowledge, the above-listed information I have provided is true and correct. If I ever experience any changes in my health, I will inform the doctor and/or staff at the time of my next appointment. I understand and acknowledge that it is my responsibility to ensure the office is aware of any changes in my health status to ensure my safety and well-being during any dental treatment I may receive now or in the future.

→
 Signature of Patient, Parent, or Guardian Date

Doctor Signature Date

Primary Dental Insurance Information

Policy Holder's Last Name	First Name	Social Security Number	Date of Birth
Policy Holder's Address	City, State	Zip Code	Telephone Number
Policy Holder's Employer (If policy is through employer)	Insurance Company Name	Member ID (if not SSN)	Policy Group Number
Insurance Company Address	City	State	Zip Code

Secondary Dental Insurance Information

Policy Holder's Last Name	First Name	Social Security Number	Date of Birth
Policy Holder's Address	City, State	Zip Code	Telephone Number
Policy Holder's Employer (If policy is through employer)	Insurance Company Name	Member ID (if not SSN)	Policy Group Number
Insurance Company Address	City	State	Zip Code

Medical Insurance Information ← IMPORTANT WE CAN BILL MEDICAL

Do you have medical Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you Suffer From TMJ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have Sleep Apnea or do your Snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you Have Bad Breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Consent for Initial Examination

I understand and acknowledge that I give permission to my dentist for his/her clinical team to take the necessary x-rays, photos, or study models ("impressions") required to complete my diagnosis and treatment.


X
2

Signature of Patient, Parent, or Guardian Date


Acknowledgement of Privacy Practices

You MAY refuse to sign this Acknowledgement

Patients: A copy of our Privacy Policy, in compliance with HIPAA law, is made available all of our patients for their review. You may also request a copy of this notice, which we will provide in-office. (A copy of the privacy policy is available at the front desk.)

I, the undersigned patient, acknowledge that a copy of this office's privacy policy has been made available to me, and I understand that I am entitled to a copy upon my request.

Patient Name (Print): _____


X
3

Signature of Patient, Parent, or Guardian Date

Office Policy Acknowledgements

Please review each item and initial on in the highlighted spaces.
A copy of this form is available upon request.

Insurance Information and Consent for Billing

As a courtesy to all patients, we will verify your dental insurance benefits, as well as outline how they can be utilized to their maximum effect. However, you are responsible to know and understand your plan coverage, exclusions, and limitations. Furthermore, you should be aware of procedures that are traditionally not covered such as missing tooth restoration, Bruxism (teeth grinding), crowns, and bridges. Also, please be aware of downgraded limitations for fillings and porcelain crowns on molars, frequency limits for exams, prophylaxis, fluoride, x-rays, etc.

The estimated amount not covered by insurance is due at the time of treatment, unless other arrangements have been made with either the doctor or the front office. Accepted methods of payment are cash, personal check, or credit card (Visa, MasterCard, Discover, and American Express). For assistance with an extensive treatment program, such as a dental implant program, we offer a variety of financing options. Information is available upon request; ask at the front office.

All estimates are subject to final approval by your insurance company; therefore, any costs above coverage are subject to change dependent upon benefits paid.

I understand and acknowledge that my insurance coverage is based upon an agreement entered into between me and my insurance provider/company. Additionally, I understand and acknowledge that I am responsible for any fees or outstanding balance incurred as a result of my treatment, regardless of insurance benefits.

I also authorize the release of any and all information related to my dental claims within compliance with federal, state, and local law.

I understand and acknowledge that I assign any dental benefit payments received from my insurance company to be paid directly to Dr. Greg Rubin, DDS, c/o the Calabasas Dental Institute and its affiliated associates. I also authorize the Calabasas Dental Institute, and its staff to prepare insurance claims on my behalf and to submit them to my insurance company, as well as to receive payment on my behalf.

Please Initial to acknowledge that you have read and understood the above statement.



Initials

Treatment Plan Estimates

The Calabasas Dental Institute prepares a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to Calabasas Dental Institute/Greg Rubin, DDS when the estimate is made. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change.

If you have dental insurance, it is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your Treatment Plan Estimate of insurance benefits is based on information provided by your insurance company and by you. In all cases, you are responsible for amounts not covered by your insurance, unless prohibited by law or contractual agreement.

In all cases, we encourage all patients with insurance to refer to their member handbooks or to call their plan administrators with any questions or concerns relating to specific benefits.

Please Initial to acknowledge that you have read and understood the above statement.



Initials

Refund Policy

You may discontinue treatment and ask for a refund from Calabasas Dental Institute/Greg Rubin, DDS at any time. Calabasas Dental Institute/Greg Rubin, DDS will refund any amount paid for treatment that you did not receive, except when Calabasas Dental Institute/Greg Rubin, DDS's policy for Interrupted Services, set forth below, applies. Requests for refunds must be submitted to the Calabasas Dental Institute in writing, and are subject to thorough review and audit. Expenses incurred by the Calabasas Dental Institute, its associates, or any outside specialists and/or providers contracted by the Institute to assist in providing treatment and care, shall be the responsibility of the patient, and may be deducted from any refund amounts.

Refunds will be made in the same manner as the original payment, except that cash payments will be refunded by check.

Any refund of payments made through a third-party, like a credit card or consumer loan payment, must be refunded to the original third-party account. Once the refund is processed it will be applied to the cardholder/account holder balance and will be reflected on your statement within the next two billing cycles. Remaining credit balances may be refunded by check and may take up to 30 days to be processed. Please contact your third-party lender directly for more information.

All requests for refunds should be sent directly to the following address:

Calabasas Dental Institute – Attn: Refund Processing – 4764 Park Granada – Suite 107 – Calabasas, CA 91302
Or email: info@calabasasdentalinstitute.com

Please Initial to acknowledge that you have read and understood the above statement.



Initials

Treatment Cancellation and Interrupted Services Charges

Patients requiring dentures may cancel their dentures at any time during the fabrication process prior to the completion of your dentures. If you choose to cancel prior to completion, you will be charged \$100 per visit for each step in the fabrication process, not to exceed \$300, depending on how many steps have been completed. Once your denture is fabricated, you are responsible for its full fee.

Patients requiring crown or bridge services may cancel treatment with no charge prior to natural tooth structures being prepared or altered for the prosthetic. Patients who undergo tooth preparation for crown or bridge services are liable for the estimated full cost of the services even if they choose not to complete treatment.

Please Initial to acknowledge that you have read and understood the above statement.



Initials

Financial Charges

Below is a list of additional charges your account with the Calabasas Dental Institute might incur and the circumstances under which they would be applied:

There is a \$25 fee for returned checks.
 All accounts over-due by sixty (60) days will be subject to an interest charge of 1.5% per month as mandated by state law.
 CDI reserves the right to apply a \$20 rebilling fee, and \$25 late fee for any overdue or delinquent financial agreements.
 We reserve the right to report any overdue balances to credit reporting agencies and bureaus.

Please Initial to acknowledge that you have read and understood the above statement. →

Initials

Past-Due Accounts

In the event that your account is turned over to a collection agent, you agree to pay all fees including but not limited to attorney's fees, court costs, collection agency fees, etc. that the Calabasas Dental Institute incurs. The Calabasas Dental Institute reserves the right to assess an eighteen percent (18%) APR charge to your account when it becomes 30 days past due.

Please Initial to acknowledge that you have read and understood the above statement. →

Initials

Missed Appointment Fee

Please note that we reserve the right to assess a fee for missed appointments, which will be billed at \$45 per half-hour scheduled (an average of \$90 for a typical appointment), which the appointment is broken without at least 24 hours notice. We are more than happy to reschedule your appointment if necessary; feel free to contact us if you need your appointment time moved.

Please Initial to acknowledge that you have read and understood the above statement. →

Initials

TRANSFERRING RECORDS

For your records to be transferred, you will need to provide us with a written request. We are able to mail, fax, or e-mail all patient records created and maintained by the Calabasas Dental Institute (Greg Rubin DDS & Associates) with a minimum of eight (8) working hours advanced notice to prepare them. Should your record be more than two years old, we will require at least three (3) business days. Copies of records made for personal use will be subject to a charge as determined by this office.

Please Initial to acknowledge that you have read and understood the above statement. →

Initials

The above agreement is entered by Greg Rubin, DDS & Associates ("Provider of Professional Services" and "Creditor") and myself ("Patient/Debtor"). By signing below, I certify that I have read and understood the information contained in the above agreement, entered into by myself and the Calabasas Dental Institute/Greg Rubin DDS & Associates, and I agree to the terms and policies as they are outlined.

X 4 _____
 Signature Date

Printed Name of Patient, Parent, or Guardian

The following signature must only be completed if it differs from the one above.

X 5 _____
 Signature Date

Printed name of Party Responsible for Payment

Photo & Images Consent

Throughout the course of your relationship with us, as a result of treatment or during periodic examination, we will be taking pictures of your teeth, smile, or entire face. We will keep these images on file insurance and liability reasons.

In addition, with cases similar to the treatment you have received, we may use the images as visual aids for other patients attempting to choose between various treatment options where the treatment you undertook is one being considered. **Your identity will NOT be provided with any photographs, and we maintain strict standards to ensure the highest level of care for your privacy.**

By AGREEING to these terms, I agree to give the Calabasas Dental Institute (Greg Rubin, DDS, his associates, and staff) permission to take, as well as the use of, photos and digital images of myself and my dental work free of charge. I understand that these photos/images may be used for, but not limited to, the following activities: internal office use, the website of Calabasas Dental Institute, and for educational uses. I also understand that I reserve the right to revoke my permission to use these photographs/images at any time by contacting the Calabasas Dental Institute in writing.

CHECK ONE: I **AGREE** to the above terms. I **DO NOT AGREE** to the above terms and I hereby reserve the rights to my images/photos.

→ X 6 _____
 Signature of Patient, Parent, or Guardian Date

Patient-Dentist Arbitration Agreement

Article I.

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, would 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 or arbitration proceedings. Both parties of this contract by entering into it, have given 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.

Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

Article II.

A. Parties to the Agreement:

The term "patient" as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "doctor" as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities, and intends to bind each of them to arbitration to full extent permitted by law.

B. Treatment Covered:

Patient understands and agrees that any dispute of the sort described in Article I between doctor and patient will be subject to compulsory, binding arbitration.

C. Coverage of Pre-Natal Claims (If Applicable):

Patient understands and agrees that, if doctor treats her during pregnancy, any dispute or sort described in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

Article III.

A. Informal Resolution of Disputes:

In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient will promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running or statute of limitations for ninety (90) days.

B. Method of Initiating Arbitration:

If the dispute is not resolved by mutual Agreement within ninety (90) days, patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by the chief administrator of JAMS ENDISPUTE. The arbitrator must be selected within twenty-one (21) days of the signature on the receipt for a letter sent certified mail return receipt request demanding that a dispute submitted to arbitration. Following the selection of the arbitrator, arbitration must be held within thirty (30) days.

C. Applicable Law:

The arbitration shall be conducted pursuant the California Arbitration Act (C.C.P. 1280-1296). The Arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California, including the provisions of the Medical Injury Compensation Reform Act 1975 which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California.

The arbitrator shall not have the power to commit errors of law or legal reasoning, and the arbitrator's decision may be vacated or corrected pursuant the California Code of Civil Procedure Sections 12806.2 or 12086.6 for any such error.

The prevailing party shall be entitled to attorney fees.

Article IV.

A. Revocation:

If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notice within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY MUTUAL ARBITRATION AND YOU ARE GIVING UP RIGHT TO JURY OR COURT TRIAL, SEE ARTICLE I OF THIS CONTRACT.

PATIENT'S NAME: (Please Print): _____ DATE: _____

SIGNED: _____ SIGNED: _____