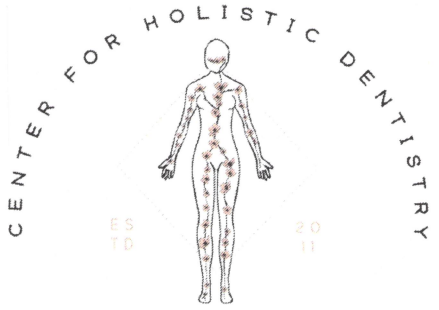
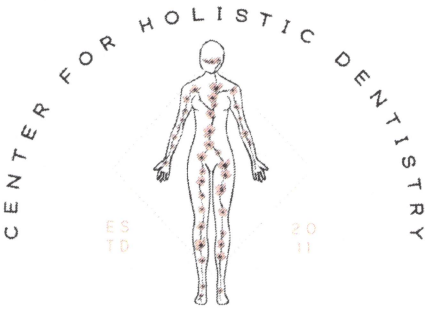


Patient Information

Name (First, Middle, Last)		Date
Home Address	City	Zip
Date of Birth	SSN	Marital Status
Cell Phone	Home Phone	Work Phone
Email address	Employer	Occupation
Drivers License #	State Issued	Exp Date
Name of Spouse/Guardian/Emergency	Relationship	Phone Number
Person Responsible for Account	Preferred Time to Call	Preferred Phone

How did you find our Office?



Insurance Information

Primary Dental Insurance (please provide front and back copy of card) Group Number

Subscriber Name Subscriber SSN Insured DOB

Secondary Dental Insurance (please provide front and back copy of card) Group Number

Subscriber Name Subscriber SSN Insured DOB

Insurance Policy

We are In-Network Providers for Delta Dental Premier.

We are Out of Network Providers for MOST PPO insurances including: Aetna PPO Cigna PPO, Beam Dental PPO, Metlife PPO, Guardian PPO, United Concordia PPO, United Healthcare PPO, Principal PPO, Premier Access PPO, Lincoln Financial PPO .

The insurance companies we do not submit to but are happy to provide you with a superbill for reimbursement are: Medicaid, Medical, Anthem Blue Cross, Blue Shield

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke of chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____
Dr.'s name? _____ Phone _____ Fax _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, pills or drugs? What? _____ Yes No
Are you taking any medication for osteoporosis such as Fosamax? _____ Yes No
Are you taking any blood thinners such as Aspirin, Coumadin, or Warfarin? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber ☐ Other _____

Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease/Surgery*	○	○	Bruise Easily/Blood Disease	○	○	Emphysema	○	○	Yellow Jaundice	○	○	Cold Sores	○	○
Heart Murmur*	○	○	Anemia	○	○	Tuberculosis	○	○	Kidney Problems	○	○	Fever Blisters	○	○
Irregular Heart Beat	○	○	Excessive Bleeding	○	○	Cancer	○	○	Renal Dialysis	○	○	Herpes	○	○
Angina/Chest Pain	○	○	Sickle Cell Disease	○	○	X-Ray Treatments (Radiation)	○	○	Thyroid Disease	○	○	Stroke	○	○
Heart Attack/Failure	○	○	Hemophilia (Bleeding Problem)	○	○	Chemotherapy	○	○	Parathyroid Disease	○	○	Convulsions	○	○
Congenital Heart Disorder	○	○	Leukemia	○	○	Stomach/Intestinal Disease	○	○	Arthritis/Gout	○	○	Epilepsy or Seizures	○	○
Mitral Valve Prolapse*	○	○	Recent Blood Transfusion	○	○	Ulcers	○	○	Rheumatism	○	○	Fainting or Dizziness	○	○
Scarlet Fever	○	○	Swelling of Limbs	○	○	Recent Weight Loss	○	○	Pain in Jaw Joints	○	○	Glaucoma	○	○
Rheumatic Fever*	○	○	Lung Disease	○	○	Frequent Diarrhea	○	○	Cortisone Medicine	○	○	Tumors or Growths	○	○
Artificial Heart Valve*	○	○	Breathing Problem	○	○	Diabetes	○	○	Artificial Joint*	○	○	Nervousness	○	○
Heart Pace Maker*	○	○	Shortness of Breath	○	○	Excessive Thirst	○	○	Venereal Disease	○	○	Psychiatric Care	○	○
Pulmonary Shunt	○	○	Frequest Cough	○	○	Hypoglycemia	○	○	AIDS	○	○	Alzheimer's Disease	○	○
High Blood Pressure	○	○	Hay Fever	○	○	Liver Disease	○	○	HIV Positive	○	○	Allergies (Medicines)	○	○
Low Blood Pressure	○	○	Sinus Trouble	○	○	Hepatitis A (Infectious)	○	○	Genital Herpes	○	○	Allergies (Pollen / Dust)	○	○
Bacterial Endocarditis	○	○	Asthma	○	○	Hepatitis B or C	○	○	Drug Addiction/Alcoholism	○	○	Hives or Rash	○	○
Unexplained Fever	○	○	Bloody Sputum	○	○	Night Sweats	○	○	Tattoos/Body Piercing	○	○	Ever taken fen-phen?*	○	○

Have you ever had any other serious illness not checked above? Discuss _____ Yes No
Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

OFFICE USE ONLY

Reviewed By Doctor _____ Date _____ BP _____
History Review and Significant Findings _____
Prophylactic Antiobiotic ○ No ○ Yes _____ Medical Clearance Needed ○ No ○ Yes

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____

Office Policy and Informed Consent

Patient Name _____ Date _____

WORK TO BE DONE
I understand that I am having the following work done Exam ___ X-Rays ___ Periodontal Evaluation___ Diagnostic Models ___ (Initials _____ Date _____)

DRUGS AND MEDICATIONS
I understand that antibiotics, analgesic and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock. (Initials _____ Date _____)

CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make any/all changes and additions as necessary and understand that these changes will be explained to me.
(Initials _____ Date _____)

CROWNS, BRIDGES, INLAYS AND ONLAYS
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown; bridge, inlay or onlay (including shape, fit, size and color) will be before cementation. It is also my responsibility to return for permanent cementation within 30 days from tooth preparation unless specified by the doctor. Excessive delays may allow for tooth movement.This may necessitate a remake of the crown, bridge, inlay or onlay. I understand that there will be additional charges for remakes due to my delaying permanent cementation.
Teeth being treated: (Initials _____ Date _____)

PERIODONTAL LOSS (TISSUE AND BONE)
I understand that I have a serious condition, causing gum and bone inflammation or loss that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition. Area being treated (Initials _____ Date_____)

TEMPORARY COMPOSITE RESTORATION
I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. Composite fillings can last from 30 days to five years. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.Teeth being treated (Initials _____ Date_____)

REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc) and I authorize the dentist to remove the following teeth and any others necessary for reasons in *CHANGES IN TREATMENT PLAN,* I understand removing teeth does no always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding teeth (Parasthesia) that can last for an indefinite period of time or fracture of jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.
Teeth being extracted (Initials _____Date_____)

DENTURES
I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after removal of teeth) may be painfull. Immediate dentures may require considerable adjusting and several relines, A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of more than 30 days there will be additional charges.
Teeth being extracted (Initials _____Date_____)

INSURANCE & PAYMENT

It is the policy of this office that payment is due and payable on the day of treatment or prepaid in advance for dental procedures. All professional services are charged directly to the patient, and the patient is solely responsible for the payment of that service. As a courtesy we will submit your insurance claim to your insurance provider. We will have your dental insurance provider reimburse you for all your dental visits. It normally takes 3-4 weeks for your insurance claim to be processed.

We do not render our services on the basis that the insurance company will pay any or all of our fees. Most insurance companies have limitations: some pay a set amount, some pay a percentage and some pay nothing at all. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collections fees, or court costs that may be incurred to satsfy this obligation.

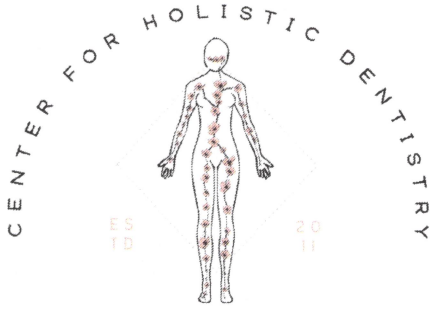
I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist is responsible for my dental treatment.

I authorize any of the doctors with the assistance of the dental auxiliaries to proceed with and perform the dental restorations and treatment as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnoes circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costat that may be incurred to satisfy this obligation.

I understand and agree to the above terms and acknowledge that I have received from Center for Holistic Dentistry a copy of the Dental Materials Fact Sheet at my specified request.

Signature:_____ Date _____

Doctor: _____ Witness _____



Dental-Patient Arbitration Agreement

ARTICLE 1: AGREEMENT TO ARBITRATE: It is understood that any dispute as to dental malpractice, that is as 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 law, and not by 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 any such dispute decided in a court of law before 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 or 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 (MamtaDalwani, DDS, MamtaDalwani DDS, Inc, Center For Holistic Dentistry) and the dentists partners, associates, associations, corporation of partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, including but not limited to all claims or personal injury, 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 shallnot 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 with in thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro raa share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from a 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 issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the investigation and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, upon such intervention and joinder and 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 judgments or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrators.

ARTICLE 4: GENERAL PROVISIONS: All Claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be 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 statue 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 natter 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 signature. It is the intent of the agreement to apply to all medical services rendered any time for any condition.

ARTICLE 6: RETROACTIVE EFFECT: If patient intends this agreement to cover service rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services:

_____
Patient's or Patient's Representative's Initials

If any provisions of this arbitration agreement are held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

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

NOTICE: BY SIGNING THS 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.

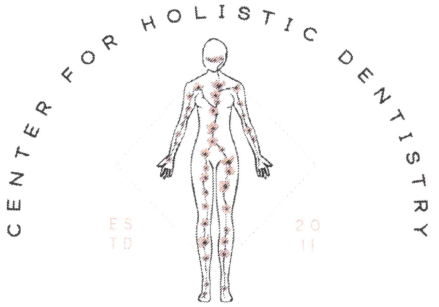
By:_____ _____
Dentist's or Dentist's Representative's Signature Date

_____
Dentist's or Dentist's Representative's Name (Print)

By:_____ _____
Patient's or Patient's Representative's Signature Date

_____
Patient Name (Print)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records



RESERVATION AND SCHEDULE CHANGE POLICY

Unanticipated events happen. It's a fact of life. Recognizing this, and in an effort to be fair to all of our valued patients the following is our office policy on cancellations.

- **48 business hours advanced notice is required for scheduling changes.**
- This policy gives other patients the opportunity to schedule an appointment. If you are unable to provide 48 hours advance notice you will be charged **$125 for every hour scheduled**for their missed appointment.
- Anyone who forgets or chooses to forgo their appointment for any reason will be considered a "no show" and will be charged **$125 for every hour scheduled**for their missed appointment.
- If you arrive late to your appointment your session may be shortened in order to accommodate on-time clients. Your provider will determine if there is enough time remaining to start treatment.
- **All patients with Monday appointments must notify the office of their schedule changes by Thursday before 5 pm to avoid a $125 charge.** For those patients whose schedule does not allow for this notice we kindly ask that you schedule your appointments on Tuesday, Wednesday or Thursday.
- **All treatment appointments require payment in full at the time of scheduling.**

We hope that you understand that this policy has been implemented to maintain the highest level of patient care. Dr. Dalwani's vision is characterized by private one on one time with each of her patients individually and we schedule based on her philosophy and in accordance with safe social distancing of patients in mind. Each and every appointment space is important, and as a courtesy to all we do not overbook to compensate for those who fail to honor their appointments. Thank you for your cooperation.

SIGNATURE_____ DATE_____

Center for Holistic Dentistry - 12381 Wilshire Blvd, Suite 103 Los Angeles,CA 90025 - (310) 207-4617
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