Patient Information

Last Name: _____ M_____ First Name _____
Preferred Name:_____ Home phone: (_____)_____
Address: _____ City:_____
State: _____ Zip: _____ Gender: M ○ F ○ Unknown ○
Marital Status: Single ○ Married ○ Child ○ Widowed ○ Divorced ○
Driver's License No._____ State:_____
Birth date:_____ Soc. Security #:_____
Email: _____
Wireless Phone: (_____)_____ if you would like to receive Text Messaging :
Wireless Phone Carrier: Verizon○ AT&T○ T-Mobile ○ Metro PCS○ Sprint ○ Nextel○
Other Wireless Carrier _____

Occupation: _____ Employer:_____
Bus. Address: _____ City:_____
State: _____ Zip: _____ Work phone: (_____)_____
Preferred Contact Method: Do not call ○ Home○ Work○ Cell○ Email○ Text Message○

Referred by:_____
Spouse's Name: _____ _____ _____
Why did you come to our office?_____
Person to contact in case of emergency _____
Relationship_____ Phone (_____)_____
Name of person financially responsible for patient _____
Billing address _____

Dental Insurance Information

Insured's name _____
Birth date:_____ Soc. Security #:_____
Address_____
Relationship to Subscriber: Self ○ Spouse○ Child○ Life Partner○ Other_____
Insurance Co. _____ Phone (_____)_____
Insurance Co. Address: _____ City:_____
State: _____ Zip: _____ Group No. _____
Do you have dual coverage? Yes○ No ○ If yes: Please complete the following secondary insurance information
Insured's name _____Insured's Soc. Sec. # _____
Birth date:_____ Insurance Company _____
Ins Co Address _____
Group No. _____

Patient's Initials_____

TERMS AND CONDITIONS

The under signed hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. I have answered all questions truthfully and to the best of my knowledge. All emergency dental services, or any dental services performed without prior financial arrangements, must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account.

Assignment of insurance: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy. A service charge of 1 1/2 % per month (18% per annum) (but in no event more than the maximum rate permissible under state law will be charge on the unpaid principle balance on all accounts not paid within 90 days of treatment date. I understand that the fee estimated listed for this dental case can only be extended for the period of six months from the date of the patient's examination. Additionally, I agree that a waiver for any breach of any proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content. Lastly, I understand that where appropriate, credit bureau reports may be obtained.

TREATMENT AND ARBITRATION AGREEMENT

With regard to dental care and services provided or to be provided by Dr. Haber is agreed that Dr. Haber will provide dental care and services to the patient, to the best of his skills and knowledge, which dental care in the light of circumstances is possible and practical. It is agreed that because of differences in human constitution and response, it is in no way possible to warrant the outcome of any medical or dental service. It is understood that any dispute as to dental malpractice, that is as to where 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 rights\ to have any such dispute decided in a court of the law before jury, and instead are accepting the use of arbitration. Within a reasonable time the two arbitrators shall select a Licensed Dentist as neutral arbitrator and give notice to the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time. All notices or other papers required to be served by United States mail. The arbitration shall be conducted in accordance with and governed by the provision of Title 9 of the California Code of Civil Procedure.

By signing this agreement, the patient understands that the patient's rights to a jury trial are waived.

All services are rendered and accepted under the terms and conditions printed above:

Signed: _____ Date:_____

Authorization must be signed by the patient, or by the nearest relative in the case of minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

Doctor signature: _____Date: _____