Capital Dental Group

Happy Teeth 7 Days A Week!

PATIENT REGISTRATION

PATIENT INFORMATION

CHART#________________

NAME____ BIRTHDATE__________________ AGE_______

SOC.SEC#______________________ CELL# __________________________ HOME# __________________________

ADDRESS____ CITY ______________________ ZIP ___________

EMAIL ____

PATIENT'S EMPLOYER ____ WORK# __________________________

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

SPOUSE NAME ___________________________________ DOB_________________ PH#_______________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT – IF OTHER THAN PATIENT

NAME____ BIRTHDATE________________________

ADDRESS____ CITY _____________________ ZIP ___________

SOC.SEC#_______________________ CELL# ____________________ RELATIONSHIP TO PATIENT______________

IS THIS PERSON A PATIENT IN OUR OFFICE? ☐YES ☐NO

DENTAL INSURANCE INFORMATION

☐NO INSURANCE

PRIMARY INSURANCE COMPANY ____ GROUP#__________________

EMPLOYER NAME ____ SUBSCRIBER ID#_________________________

SUBSCRIBER NAME _______________________________________ DOB ______________________

SUBSCRIBER SOC. SEC# ___________________________________ RELATIONSHIP TO PATIENT ________________

SECONDARY INSURANCE COMPANY ____ GROUP#_________________

EMPLOYER NAME ____ SUBSCRIBER ID#_________________________

SUBSCRIBER NAME _______________________________________ DOB ______________________

SUBSCRIBER SOC. SEC# ____________________________________ RELATIONSHIP TO PATIENT _______________

PERSON TO CONTACT FOR EMERGENCY

NAME____________________________________ RELATIONSHIP__________________ PH#____________________

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐FAMILY/ FRIEND ☐INSURANCE LIST ☐RADIO AD ☐YELLOW PAGES ☐SAW BUILDING
☐TV-AD ☐TV-AD IMPLANTS ☐IMPLANT INFORMERCIAL (WELLNESS HOUR) ☐OTHER___________________

Patient/Responsible Party Signature | Print Name | Date

DEPENDENT INSURANCE QUESTIONNAIRE

Must be completed for all dependents that are covered under their parent/ guardian's dental insurance.

Insurance companies require the following information for proper claim handling. This information helps insurance companies determine which plan will pay as primary when a dependent has double coverage.

Failure to provide this information may result in delays of processing or nonpayment of insurance claims.

CHILD INFORMATION

NAME ______________________________________ BIRTHDATE______________________________

WHO DOES CHILD PRIMARILY RESIDE WITH?
□BOTH NATURAL PARENTS □MOTHER □FATHER □OTHER________________________________

IF DEPENDENT IS OVER THE AGE OF 19:
IS CHILD A FULL TIME STUDENT? □YES □NO

IF YES- NAME OF SCHOOL: ___________________________________

LOCATION OF SCHOOL: ______________________________________

NUMBER OF UNITS: ________ EXPECTED GRADUATION YEAR __________

PARENT INFORMATION

NATURAL MOTHER NAME _______________________________ DOB ______________________

NATURAL FATHER NAME ________________________________ DOB ______________________

STEP-MOTHER NAME _______________________________ DOB ______________________

STEP-FATHER NAME ________________________________ DOB ______________________

ARE NATURAL PARENTS:
□MARRIED □SEPARATED □DIVORCED □TOGETHER, NON-MARRIED □NEVER MARRIED

IF DIVORCED/SEPARATED:
DO NATURAL PARENTS SHARE JOINT CUSTODY? □YES □NO

IF NO, WHO IS CUSTODIAL PARENT? _________________________

WHICH PARENT IS COURT-ORDERED TO CARRY HEALTH INSURANCE?
□NON-APPLICABLE □MOTHER □FATHER □BOTH

_____________________________________ ____________________________________ ________________
Parent/ Guardian Signature Print Name Date

MEDICAL HISTORY FORM

PATIENT NAME___________________________________ BIRTHDATE ____________________ AGE ________

Are you allergic to any of the following?

□No Known Drug Allergies □Aspirin □Penicillin □Codeine □Sulfa Drugs
□Local Anesthetics □Acrylic □Metal □Latex
□Other ____

Are you under a physician's care now? □Yes □No If Yes, Explain: ____________________________
Have you been hospitalized or had a major operation? □Yes □No If Yes, Explain: ____________________________
Have you had a serious head or neck injury? □Yes □No If Yes, Explain: ____________________________
Is pre-medication required before dental visits? □Yes □No If Yes, Explain: ____________________________
Are you taking any medications, pills, or drugs? □Yes □No List: ____________________________________
Have you taken Phen-Fen or Redux? □Yes □No If Yes, Explain: ____________________________
Have you taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? □Yes □No If Yes, Explain: ____________________________
Do you use tobacco? □Yes □No If Yes, How Often: _________________________

List any recreational drug use __________________________

Woman, are you: □Pregnant □Trying to get pregnant □Taking oral contraceptives □Nursing

Do you have, or have you had, any of the following? Check all that apply

□Abnormal Blood Pressure
□High □Low
□AIDS/ HIV Positive
□Alzheimer's Disease
□Anemia
□Artificial Heart Valve
□Artificial Joint
□Asthma/ Breathing Problems
□Autism Spectrum Disorder
□Blood Transfusion
□Cancer __________________
□Chemotherapy

□Congenital Heart Disease
□Diabetes
□Epilepsy or Seizures
□Excessive Bleeding
□Fainting/ Dizziness
□Glaucoma
□Heart Problems
____
____
□Hemophilia
□Hepatitis □A □B □C
□High Cholesterol

□Kidney Problems
□Liver Disease
□Mitral Valve Prolapse
□Organ Transplant
□Radiation Therapy
□Shingles
□Sickle Cell Disease
□Sleep Apnea
□Stroke
□Thyroid Disease
□Tuberculosis

Have you had any serious illness not listed above? □Yes □No ____

Comments: ____

____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform Capital Dental Group of any changes in my medical status.

_____________________________________ ____________________________________ _________________
Signature Relationship to Patient Date

OFFICE FINANCIAL POLICIES

PAYMENT

Patient co-pays are due in full at the time of service, unless prior financial arrangements are made.
We offer the following payment options: exact cash, checks, money orders, Visa, MasterCard, Discover, CareCredit, Lending Club, and automatic monthly payment plans for specific extended treatment.

PAST DUE BALANCES

A past due balance is any amount owed from a prior visit where insurance is not pending and an automatic payment plan has not been set up. A past due balance must be paid in full before incurring any new charges We will make all attempts to contact you to collect a past-due balance. Severely delinquent accounts may be forwarded to a third-party collection agency.

RETURNED CHECKS

Checks returned for insufficient funds will be subject to a $25.00 service fee.

DENTAL INSURANCE

Is it the patient's responsibility to provide us with up-to-date insurance information at the time of each visit, and to inform us if annual benefits were used at another office since your last visit. We estimate insurance coverage to the best of our ability based on benefits provided by your insurance company, but are unable to guarantee estimated coverage. Patient/responsible party is responsible for full payment of all services rendered, regardless of insurance coverage or payment. Patient understands that all prosthetic fees are incurred at the time the prosthetic has been initialized. If the prosthetic is not delivered to the patient due to non-compliance, the patient/responsible party, is responsible for full fees incurred.

It is the patient/subscriber's responsibility to respond to all requests from their dental insurance. If a claim payment is delayed pending information from the subscriber, our office will attempt to collect insurance payment for no longer than 60 days before payment then becomes the responsibility of the patient/ responsible party.

GENERAL DENTISTRY INFORMED CONSENT

Patient authorizes doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor, regardless of insurance eligibility or coverage, to make a thorough diagnosis of dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Patient agrees to the use of anesthetics, sedatives, and other medications necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

In the event that a patient is dissatisfied with their treatment, patient agrees to have any dispute adjudicated by the Peer Review Board.

Patient acknowledges that they have received, or have had an opportunity to review a copy, of the Dental Materials Fact Sheet dated 2004.

My signature below serves as statement of understanding and agreement to the above.

________________________________	________________________________	______________
Patient/Responsible Party Signature	Print Name	Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

PATIENT NAME___________________________________ BIRTHDATE ___________________

I give consent to the doctor's or designated staffs use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only a minimum amount of information necessary to provide quality care will be used or disclosed. A notice fully outlining the protection of your personal health information is available at the front desk (HIPAA Act).

From time to time, we would like to tell patients about products and services that we think may be of interest.

We make every effort to comply completely with HIPAA privacy regulations. At the same time, we do not want our patients to be inconvenienced when they wish to have spouse or family member call us for healthcare information pertaining to you and our office.

<u>Please list designee recipients who can obtain your health information:</u>

____ __________________ __________________________
Name DOB Relationship

____ __________________ __________________________
Name DOB Relationship

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation at the following address: 8701 Camino Media, Bakersfield, CA 93311

I understand that I have the right to refuse to sign this acknowledgement, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

____________________________________ ___________________________________ _______________
Patient/Responsible Party Signature Print Name Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐Individual refused to sign
- ☐Communication barriers prohibited obtaining the acknowledgement
- ☐An emergency situation prevented us from obtaining the acknowledgement
- ☐Other. Specify: ____

Staff Signature: ____________________________________ Date:________________________

PATIENT'S FREEDOM OF CHOICE

THE FOLLOWING NOTICE IS REQUIRED BY LAW

You may be referred to Convenient Dental Imaging for a dental computerized axial tomography scan. Each of the following dentists has a financial interest with Convenient Dental Imaging:
Richard Casteen, DDS., Wade Logan, DDS., and Stephen Wilson, DDS.

You are free to choose any dentist or imaging center you wish for obtaining services that may be ordered or requested for you by any of the dentists in our office. The following facilities provide dental computerized axial tomography scans within twenty-five miles of this office:

James N.Clark, DDS
1805 28th St. Bakersfield, CA 93301
661-325-5751

Lam Trinh, DDS/ Thi Thi Trinh, DDS
Excel Dental, Inc
3400 Calloway Dr, Suite 303. Bakersfield, CA 93312
661-213-3526

Bakersfield Radiographic Center
2920 F St, Suite B2. Bakersfield, CA 93301
661-322-2089

Stanley S. Koh, DDS
3301 19th St, Suite B. Bakersfield, CA 93301
661-327-2051

Truxtun Radiology Medical Group – for implants only
4000 Empire Dr, Suite 100. Bakersfield, CA 93309
661-325-6800

Your dentist would be happy to discuss any of these alternatives with you. Potential sources of information concerning alternatives can also be obtained from the Yellow Pages, the internet, or the Dental Board of California. The following address is provided for the filing of any complaints relevant to this notice or the services provided:
Dental Board of California
2005 Evergreen St., Suite 1550
Sacramento, CA 95815

I hereby acknowledge receipt of this notice.

______________________________	______________________________	____________
Patient/Responsible Party Signature	Print Name	Date

Arbitration Agreement

Section 1: Agreement to Arbitrate _________ (Patient's or Patient Representative's Initials)
It is understood that any dispute as to dental malpractice, meaning 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 a 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 law before a jury, and instead are accepting the use of arbitration.

Section 2: All Claims Must be Arbitrated _________ (Patient's or Patient Representative's Initials)
The term "dentist" as used in the agreement includes the undersigned dentist and Casteen Dental Corp. doing business as Capital Dental Group, all independent contractors who practice dentistry at the undersigned dentist's place of business, and any employees' agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities. The dentist signing this Agreement signs it on behalf of all the foregoing individuals and entities, intends to bind each of them to arbitration to the full extent permitted by law. 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 to the "patient" 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 of any of 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.

Section 3: Procedures and Applicable Law _________ (Patient's or Patient Representative's Initials)
In the event the patient feels that a problem has arisen in connection with the dental care rendered by the dentist to the patient, patient will promptly notify the dentist so that the dentist may have the opportunity to resolve the matter. Notice must be given in writing and shall stop the running of the statute of limitations for ninety (90) days. A demand for arbitration must be communicated in writing to all parties. The arbitration shall be submitted to ADR Services, Inc., whose phone number is
(310) 201-0010. ADR Services shall provide the names of three (3) arbitrators. Each party shall be entitled to strike the name of one (1) arbitrator and ADR Services shall then select the arbitrator from the list of names that were not stricken. ADR Services shall provide the names of the arbitrators to the parties and the parties shall have thirty (30) days to strike the name of one (1) arbitrator. Each party to the arbitration shall pay such party's own benefit. The parties agree that the arbitrator has 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. Any arbitration under this agreement is to be held in the city of Bakersfield, county of Kern, state of California. 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 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 within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 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 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 arbitrator.

Section 4: General Provisions _________ (Patient's or Patient Representative's Initials)
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 statute 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.

Section 5: Revocation _________ (Patient's or Patient Representative's Initials)
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 any time for any condition. However, dentist and patient agree that any claim arising from dental services rendered prior to revocation shall be subject to arbitration.

Section 6: Retroactive Effect _________ (Patient's or Patient Representative's Initials)
Patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment). Effective as of the date of first dental services

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 of any other provision. Any negotiations or prior agreements are superseded by this arbitration agreement. Any amendment to this arbitration agreement must be in writing and signed by the parties hereto. Any controversy concerning the interpretation or application of the agreement itself shall also be submitted to arbitration in the manner provided above.

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 SECTION 1 OF THIS CONTRACT.

Print Patient's Name: ____

____	________________________
Patient/Responsible Party Signature	Date
____	________________________
Print Name	Relationship to Patient
____	________________________
Dentist's or Authorized Representative's Signature	Date