Reset Form

PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____ Nick Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ ❑ Male ❑ Female SS#: _____

Address: _____ City: _____ State: SS _____ Zip: _____

Employer: _____

State ID/Driver's License #: _____ E-mail Address: _____

Name of Physician: _____ Physician Phone: _____

In case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	❑	❑	Excessive Bleeding	❑	❑	Jaundice	❑	❑	Respiratory Problems/Disorders	❑	❑
Alcoholism	❑	❑	Epilepsy	❑	❑	Kidney Disease	❑	❑	Rheumatic Fever	❑	❑
Allergies	❑	❑	Glaucoma	❑	❑	Kidney Dialysis	❑	❑	Rheumatism	❑	❑
Anemia	❑	❑	Hay fever	❑	❑	Latex Sensitivity	❑	❑	Scarlet Fever	❑	❑
Arthritis	❑	❑	Head injuries	❑	❑	Lupus	❑	❑	Seizures/Fainting spells	❑	❑
Asthma	❑	❑	Hearing Impaired	❑	❑	Low Blood Pressure	❑	❑	Sinus Problems	❑	❑
Blood Disease	❑	❑	Heart Disease	❑	❑	Malignancies	❑	❑	Stomach Ulcers	❑	❑
Bone Disease	❑	❑	Heart Valve, Murmur	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke	❑	❑
Cancer	❑	❑	Hepatitis/Liver Disease	❑	❑	Neck & Back Problems	❑	❑	Thyroid Disease	❑	❑
Chemical Dependency	❑	❑	Type(s) _____			Nervous Problems/Disorders	❑	❑	Tuberculosis	❑	❑
Chest Pain	❑	❑	Hepatitis Carrier	❑	❑	Pacemaker	❑	❑	Tumors or growths	❑	❑
Circulatory Problems	❑	❑	High Blood Pressure	❑	❑	Prosthetic Joints	❑	❑	Ulcers	❑	❑
Convulsions/Seizures	❑	❑	Hip or Joint replacement	❑	❑	Psychiatric Care	❑	❑	Venereal Disease	❑	❑
Diabetes	❑	❑	HPV	❑	❑	Radiation Treatment	❑	❑			

Medical Questions

List any medications you are taking including nonprescription drugs:

_____

_____

_____

Are you allergic to any medications? ❑ YES ❑ No If yes, please list below:

_____

_____

Are you in good health? ❑ YES ❑ No

Date of last medical exam: _____

Have you ever been hospitalized? ❑ YES ❑ No If yes, what was the problem

_____

_____

Do you have any disease/problem you think we should know about? ❑ YES ❑ No

_____

_____

_____

_____

Have you had a transplant operation that has depressed your immune system? ❑ YES ❑ No

Have you had an allergic reaction to Bananas? ❑ YES ❑ No

Do you smoke or chew tobacco? ❑ YES ❑ No

Have you had Heart Surgery? ❑ YES ❑ No

Are you now under the care of an MD? ❑ YES ❑ No

Are you taking or have you ever taken bisphosphonates? (Fosamax or Actonel for osteoporosis, chemotherapy, etc) ❑ YES ❑ No

FOR WOMEN ONLY:

Are you taking birth control pills? ❑ YES ❑ No

Are you pregnant? ❑ YES ❑ No Expected delivery date: _____

Are you nursing/breastfeeding? ❑ YES ❑ No

Is there a possibility of pregnancy? ❑ YES ❑ No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Date: _____

Dental History Information

Date of last dental visit? _____

Name of your previous dentist _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? ❑ YES ❑ No

How often do you floss your teeth? _____

Do your gums bleed when you brush? ❑ YES ❑ No

Have you or a family member ever been treated for periodontal disease? ❑ YES ❑ No

Have you ever had complications from an extraction? ❑ YES ❑ No

Have you ever had a popping or clicking near your ear when you chew? ❑ YES ❑ No

Are you prone to frequent headaches? ❑ YES ❑ No

Do you grind or clench your teeth? ❑ YES ❑ No

Do you have sores, blisters or swelling on your gums lips or cheeks? ❑ YES ❑ No

Have you ever had orthodontic treatment? ❑ YES ❑ No

Dr. Signature: _____

Do you snore? ❑ YES ❑ No

Do you have problems with bad breath? ❑ YES ❑ No

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? ❑ YES ❑ No

Have you ever used an electric toothbrush? ❑ YES ❑ No

Are your teeth sensitive to hot, cold or pressure? ❑ YES ❑ No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be:

- ❑ Whiter
- ❑ Straighter
- ❑ Close space
- ❑ replace black mercury filling with tooth colored restorations
- ❑ repair chipped teeth
- ❑ replace missing teeth
- ❑ less gums showing
- ❑ replace old crowns or caps that don't match

Date: _____

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Reviewed by: _____

Patient: _____ Date: _____

Parent/Guardian (if patient is a minor): _____ Date: _____

OFFICE POLICY NOTICE TO NEW PATIENTS

Thank you for choosing Dr. Idan Snapir and The Dental Smile Center to meet your oral health care needs. During your initial visit we will perform a comprehensive oral examination to determine your existing conditions and make recommendations for your care. We use the most advanced dental technology available to be as thorough as possible.

All recommended treatment will be discussed with you in detail during the examination visit. If you have any clinical questions regarding any recommended procedure, please be sure to ask Dr. Snapir or any of his associated dentists or specialists to clarify so that you completely understand your needs and the reasons for the recommended treatment.

Following the examination, the Office Manager will review your financial obligation maximizing the value of your insurance benefits. Treatment will commence once an agreement is reached. Your patient portion for services rendered is due on the day services are provided unless other arrangements are made.

All future appointments will be confirmed in advance utilizing text messages, emails and phone calls. If you need to change any appointment for any reason, please give us the courtesy of 72 hours' notice so that The Dental Smile Center will have ample time to offer the time to another patient. Failure to notify the office in advance for any cancelled or broken appointment may result in a $50 per-hour scheduled cancellation fee with the general dentist and $150 per-hour scheduled with the specialist. We understand that your time as well as the doctor's is valuable, so we will do our best to keep our time commitment to you as well.

Thanks again for trusting The Dental Smile Center with your oral health care. We look forward to serving you for many years to come. If there is ever any issue with any aspect of your relationship with the office, please feel free to contact me.

Respectfully,

Idan Snapir DDS

X_____ _____

Please Sign Date

FINANCIAL & APPOINTMENT CONSENT FORM

Welcome to our practice!

We look forward to providing you with exceptional dental care. To provide you with the most beneficial and comprehensive service, we do ask that you review and complete our office and financial policy form.

Dental Insurance

As a complimentary service, we will file claims with your primary dental insurance company. In order for us to timely file the claim and collect payment, we ask that the correct insurance information be provided at the time of your appointment. If this information changes, it is your responsibility to update our office immediately. We will accept payment from your dental insurance company. Please note that any difference in payment from your insurance company and your account balance is your responsibility. We emphasize that as dental care providers, our relationship is with you, NOT your insurance company. Your insurance is a contract between you, your employer and the insurance company. Our office will provide you with an ESTIMATE of your out-of-pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates. While the filing of primary insurance claims is a courtesy that we extend to all our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 45 days from the date of service become the immediate responsibility of the patient and/or account holder.

Payment. Co-pays & Deductibles

Payment for co-pays and/or deductibles is due at the time services are provided. Payment may be paid by cash, check, Visa, MasterCard, Discover or American Express. Our office also accepts payment through CareCredit. CareCredit is bank financing for qualified applicants who prefer additional time to pay their balance. It is a revolving line of credit through an independent financial institution. It is designed to meet the needs of our patients and is ideal for extended treatment plans, elective procedures, emergency care, and treatment not covered by insurance. CareCredit has financing options available that include 6- and 12-month interest free payment plans, as well as an extended payment plan. We will gladly discuss your proposed treatment, financial options and any other questions you may have.

Account Balances & Charges

Any balance older than 45 days will be subject to interest charges up to 12% until the account is paid in full. If a balance remains on the account after 90 days, the account will be sent to a collection agency and additional collection fees will be applied to any unpaid balance. Any attorney or collections fees incurred due to delinquency in payment will also be charged to the patient. Any personal check returned unpaid or with nonsufficient funds (NSF) will incur charges to recover the face amount of the check, a $25 processing fee and $30 NSF check fee to absorb bank charges to our office. If financial problems occur, we ask that you contact us promptly for assistance in the management of your account.

Cancellations & Broken Appointments

In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a 72-hour cancellation notice. Your scheduled time has been saved only for you and the doctor or hygienist. Due to staff overhead that occurs in broken appointment slots, a cancellation fee of $50 per-hour scheduled is charged if a 72-hour notice is not given. A cancellation fee of $150 per-hour scheduled with the specialist is charged if a 72-hour notice is not given. We appreciate your efforts to keep scheduled appointments.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FROM SERVICES RENDERED BY The Dental Smile Center, operating as IDAN SNAPIR DDS, INC.

_____ _____

Signature of patient / parent / legal guardian Date

Office Use Only

Account Name: _____ Account#: _____

THE DENTAL SMILE CENTER

ACKNOWLEDGEMNT OF RECEIPT OF PRRIVACY PRACTICES HIPAA

I, _____, have received a copy of this office's Notice of Privacy Practices which is in compliance with HIPAA.

_____

Please Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

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

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify)

_____

_____

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WHERE ALL YOUR DENTAL NEEDS ARE UNDER ONE UMBRELLA

Arbitration Agreement

Patient's Last Name: _____ **Patient's First Name: _____**

_____ **Article 1:** It is understood that any dispute as to malpractice, that is to whether any services rendered under this contract were unnecessary, or unauthorized were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or report to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contact, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

_____ **Article 2:** I understand and agree that this Arbitration Agreement bind me and anyone else who may have a claim arising out of or related to all treatment or services provided by the provider, including any spouse or heirs of the Patient and any children, whether born or unborn at the time of occurrence of any claim. This includes, but is not limited to, any dispute arising from tort, contract, negligence or otherwise for monetary damage, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages or actions brought on behalf of patient by third parties, shall be submitted to binding arbitration and not a lawsuit. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relate to he claims against the provider and any consenting substitute provider, as well as the provider's partners, associates, associations, corporation or partnerships, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to the full and complete settlement of any dispute arbitrated under this Agreement.

_____ **Article 3:** The arbitrator shall have the authority to award any remedy or relief that a court of the state of California could order or grant, but no other remedy or relief. The award must be limited to the relief of available to a California state court and under California law for the cause(s) of action at

issue in arbitration. However, each party shall bear its own costs, expenses, legal fees, witness expenses, and 50% of the arbitrator's fees and such expenses may not be awarded against the opposing party. The provisions of California law applicable to healthcare providers shall apply including, but not limited to, California Code of Civil Procedure sections 667.7 and 425.13, and California Civil Code sections 333.1 and 333.2. I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

_____ **Article 4:** I understand that I do not have to sign this agreement to receive services, and that if I do sign this agreement and change my mind within 30 days of today, then I may cancel this agreement by giving written notice to the undersigned provider within 30 days of the date of my signature below stating that I want to withdraw from this arbitration agreement.

_____ **Article 5:** I have read and understood this Agreement. I understand that in the case of a pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

By initialing below, Patient intends and acknowledges this Arbitration Agreement to cover claims arising before the date it is signed. This Arbitration Agreement is effective as of the date of this provision of the first care or service of any kind. Patient acknowledges to have received a signed copy of this agreement.

_____

Initials of Patient or
Patient's Legal Representative

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provision shall remain in full for and shall not be affected by the invalidity of any other provision.

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

_____ **Dated: _____**

Patient, Parent, Guardian or Legally Authorized Representative of Patient)/ Relationship

Provider's Agreement to Arbitrate: In consideration of the foregoing execution of this Patient-Provider Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement and in the rules specified in Article 3 above.

_____ **Dated: _____**

The Dental Smile Center Representative

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Pre-Screen Questions:

Have you traveled recently to an area with known local spread of Covid-19 – Coronavirus? [ ] Yes [ ] No

Have you been within 6 feet of someone who tested positive for Covid-19 – Coronavirus or quarantined for possible Covid-19-Coronavirus?
[ ] Yes [ ] No

Have you been experiencing fever (over 99.6), or lower respiratory symptoms such as cough or difficulty breathing?
[ ] Yes [ ] No

Or, have you had at least 2 symptoms of: fever, chills, headache, sore throat, loss of taste or smell or generalized muscle pains?
[ ] Yes [ ] No

If you answer yes to any of these, please call the office to reschedule your appointment to a later date.

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General Dentistry Informed Consent

Patient: _____ **Dentist:**_____

1. EXAMINATIONS AND X-RAYS

I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan.
(Initials _____)

2. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)
I understand that popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. **(Initials _____)**

3. DENTAL PROPHYLAXIS (CLEANING)
I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease. **(Initials_____)**

4.Work to be done
I understand that I am having the following work done: Fillings_____, Crowns_____, Extractions _____, Dentures_____, Impacted teeth removed_____, Root Canals_____, Periodontal Treatment_____, Other_____ **(Initials_____)**

5. Drugs and medications
I understand that antibiotics , analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or and anaphylactic shock. **(Initials_____)**

6. Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions that were not discovered during examination but are found during treatment. For example, tooth decay can be closer to the nerve than radio graphically visible and this can be unknown until the decay is removed. I give my permission to the dentist to make changes and additions as necessary.
(Initials_____)

7. Removal of Teeth

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Alternatives to removal have been explained to me (root canal therapy,crowns,and periodontal surgery, etc.) And I authorized the dentist to remove the following teeth;
_____and any others necessary for reasons in paragraph #3. I understand removing teeth does not 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 tissue, or fractured jaw. I understand removal of teeth can result in par aesthesia that can last permanently or for an indefinite period, and that par aesthesia Numbness is a possible risk of injection/extraction. I understand I may need further treatment by a specialist if complications arise during the following treatment, the cost of which is my responsibility. **(Initials_____)**

8. Crowns, Bridges, Veneers, and Cosmetic Release
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, or veneers (including the shape, fit, size, and color) will be before cementation.** it is also my responsibility to return for permanent cementation within 21 days from tooth preparation. In certain cases, the dentist may determine a shorter or longer period. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes due to my delaying permanent cementation. **(Initials_____)**

9. Endodontic Treatment (Root Canal)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend it through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (retreatment or apicoectomy). I understand that the tooth may be lost despite all effort to save it. **(Initials_____)**

10. Periodontal Loss (Tissue and Bone)
I understand that I have a serious condition causing gum and bone inflammation and loss in that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition. **(Initials_____)**

11. Fillings
I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling then originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common aftereffect of a newly placed filling. **(Initials_____)**

12. Dentures/Partials
I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating our common problems. Immediate dentures (placement of a denture immediately after extractions) may be

painful. 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 inform the doctor or staff, at the time of my wax try in, if I am not happy with the appearance of my denture/partial.** I understand that by not telling someone, I am approving the color, shape and arrangement of the teeth and that after the prosthetic has gone through the final processing, changes cannot be made without incurring additional fees which I will be responsible for.

(**Initials**_____)

13. BLEACHING

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The Dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agents has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials _____)

14. NITROUS OXIDE

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials _____)

15. DENTAL BENEFITS

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the Dentist's recommendation of optimal dental treatment. **(Initials _____)**

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee exact results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized aside from written guarantees on materials or prosthetics. **I understand it is my responsibility to maintain my dental treatment through home care, cleanings, periodic examinations and X Rays, and the wearing of all prescribed appliances.**

Signature of Patient:_____ Date:_____

Signature of Witness: _____ Date:_____

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