Calabasas Dental Institute

Personal Information

Last Name	First Name	M.I.	Preferred Name

Date of Birth	Social Security Number	Gender (Check)	Marital Status
		❑ Male ❑ Female	❑ Single ❑ Married ❑ Child ❑ 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? ❑ Yes ❑ 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

❑ Referred by another Patient (Please provide appropriate information below):

Last Name	First Name	Telephone Number

Dental History

1. Do you have dental exams on a regular basis? ❑ Yes ❑ No
2. Do you think you have active gum decay or disease? ❑ Yes ❑ No
3. On a regular basis, I… ❑ Brush ❑ Floss ❑ Brush & Floss ❑ Neither
4. Do your gums ever bleed? ❑ Yes ❑ No
5. Do you like your smile? ❑ Yes ❑ No
6. Do you have any loose teeth? ❑ Yes ❑ No
7. Do you ever have clicking, popping or discomfort in your jaw? ❑ Yes ❑ No
8. Do you ever brux or grind your teeth? ❑ Yes ❑ No
9. Do you smoke cigarettes/cigars and/or chew tobacco? ❑ Yes ❑ No
10. Any sores or growths in your mouth? ❑ Yes ❑ No
11. Do you wish to speak privately with the dentist about any issues and/or problems? ❑ Yes ❑ No
12. Name of your previous/current dentist (optional): Name: _____ Phone: _____
13. 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	
❑	❑	AIDS/HIV	❑	❑	Fever Blisters/Cold Sores	❑	❑	Nervous Disorders
❑	❑	Allergies	❑	❑	Frequent Diarrhea	❑	❑	Night Sweats
❑	❑	Anemia	❑	❑	Glaucoma	❑	❑	Pacemaker *
❑	❑	Arthritis	❑	❑	Growths	❑	❑	Pain in Jaw Joints
❑	❑	Artificial Joints	❑	❑	Hay Fever	❑	❑	Phen-Phen
❑	❑	Artificial Heart Valve *	❑	❑	Head Injuries	❑	❑	Pregnancy—Due Date: _____
❑	❑	Asthma	❑	❑	Heart Attack	❑	❑	Radiation Treatment (Cancer)
❑	❑	Bacterial Endocarditis	❑	❑	Heart Disease	❑	❑	Recent Weight Loss
❑	❑	Blood Disease	❑	❑	Heart Murmur *	❑	❑	Renal Dialysis
❑	❑	Blood Transfusion	❑	❑	Heart Surgery *	❑	❑	Rheumatic Fever
❑	❑	Bloody Sputum	❑	❑	Hepatitis A	❑	❑	Rheumatism
❑	❑	Cancer	❑	❑	Hepatitis B & C	❑	❑	Scarlet Fever
❑	❑	Chemotherapy	❑	❑	High Blood Pressure	❑	❑	Sickle Cell Disease
❑	❑	Congenital Heart Disorder	❑	❑	Hypoglycemia	❑	❑	Sinus Problems
❑	❑	Cortisone Medication	❑	❑	Irregular Heart Beat	❑	❑	Stomach Problems
❑	❑	Convulsions	❑	❑	Jaundice	❑	❑	Stroke
❑	❑	Diabetes	❑	❑	Kidney Disease	❑	❑	Thyroid Disease
❑	❑	Dizziness	❑	❑	Leukemia	❑	❑	Tuberculosis
❑	❑	Drug Addiction	❑	❑	Liver Disease	❑	❑	Tumors
❑	❑	Epilepsy	❑	❑	Low Blood Pressure (Hypotension)	❑	❑	Ulcers
❑	❑	Fainting	❑	❑	Mitral Valve Prolapse *	❑	❑	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 BISPHOSPHONATE medication? *(Fosamax, Actonel, Boniva, or IV Bisphophonates)* ❑ 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.

➔ X _____ Signature of **Patient**, Parent, or Guardian _____ Date

X _____ **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?	❑ Yes ❑ No	**Do you Suffer From TMJ?**	❑ Yes ❑ No
Do you have Sleep Apnea or do your Snore?	❑ Yes ❑ No	**Do you Have Bad Breath?**	❑ Yes ❑ 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 and 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 Armen Galustian DDS, c/o the Calabasas Dental Institute and its affiliated associates. I also authorize the Calabasas Dental Institute, and it's 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/Armen Galustian, 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/Armen Galustian, DDS at any time. Calabasas Dental Institute/ Armen Galustian, DDS will refund any amount paid for treatment that you did not receive, except when Calabasas Dental Institute/Armen Galustian, 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, it's 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 (Armen Galustian 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 Armen Galustian, 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/Armen Galustian DDS & Associates, and I agree to the terms and policies as they are outlined.

Printed Name of Patient, Parent, or Guardian | X 4 Signature | Date

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

Printed name of Party Responsible for Payment | X 5 Signature | Date

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 (Armen Galustian, 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 descried 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 descried 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: _____