MMSI Dental Center

Many More Smiles Involved

Patient Information

****THIS FORM MUST BE COMPLETED FILL OUT BEFORE THE DOCTOR SEE YOU**** ALL INFORMATION PROVIDED WILL BE VERIFIED

*Account #: ________________ ***Driver License#:** ________________ **State:** ________________
*Patient's First Name: ________________ Middle Initial: ________________ Last Name: ________________
*Birth-date: ________________ *Social Security#: ________________ Sex: M _____F _____Married: ________ Single: ________
*Home Address: ________________ City: ________________ State: ________________ Zip Code: ________________
*Cell Phone: ________________ Home Phone: ________________ Work #: ________________ Alternate #: ________________
*Employers Name: ________________ Address: ________________
City: ________________ State: ________________ Zip Code: ________________ Employer Phone ________________ How long Employed ________________

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Parent or Guarantor Information: Name: ________________ Relation to Patient: ________________

***DENTAL INSURANCE INFORMATION: Yes No**
Insurance Company Name: ________________ and Phone #: ________________
Insurance type: PPO ____ HMO ____ Other ________ Policy / Group #: ________ Yearly Max: ________ Deductible: ________
Name of lnsured: Self ____ or ________________ Relation to Patient ________________ Date of Purchase: ________________
Insureds Social Sec #: ________________ Birth date: ________________ Employer's Name: ________________

***2nd DENTAL INSURANCE INFORMATION: Yes No NAME:** ________________ **PPO** ____ **HMO** ____
Name of Insured: Self ____ or ________________ Relation to Patient ________________ Year Max: ________ Deductible: ________

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***MEDICAL INSURANCE: (Some dental procedures may be covered,like CT Scan, Arestin, Sinus lifing, Bone Graft ...etc.)**
PPO Only: Yes No Insurance Name: ________________ **Policy Holder Name:** ________________
Relation to Holder: ________________ **Year Deductible: $**________ **Policy ID#:** ________________ **Group#:** ________________

Please List Two References in Case of Emergency to Notify:
Living with You: Name: ________________ Relation: ________________ Phone #: ________________
Not Living with You: Name: ________________ Relation: ________________ Phone #: ________________

***How Did You Hear of Us?** ____ Insurance Brochure or Online ____ Building Sign ____ Office Website ____ Yellow Pages ____
____ Radio I300 ____ TV ____ Google Search ____ Yelp ____ Newspaper ____ Postcard ____ Family Members____ Friends ____

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PLEASE READ THOROUGHLY BEFORE SIGNING:

I HAVE FILLED OUT THIS QUESTIONNAIRE ACCURATELY. I have informed you of all Medical Problems and allergies of which I am aware. I understand that all bridges, crowns, dentures and partials are custom-made works and the entire charge is incurred before the procedure begins. Satisfaction will be guaranteed. But if you are still not satisfied and want refund, the lab fee and materials will be deducted. I also understand that any remake of these procedures due to my failure to have them completed in the normal length of time may result in additional charges. I further realize that the financial arrangements in regards to my insurance are estimated based on normal ethical dental practices and available information concerning my insurance coverage and that I am ultimately responsible for the balance of my account if my insurance fail to pay. I also agree to keep all of my appointments and acknowledge I may be charged for failure to do so without 48-hour notice. I have been informed of all risks involved in any dental treatment and anesthesia and I am giving consent to have these services performed. By signing below, I understand that you may request a credit report on any additional applicants and me. I hereby authorize Dr. E. Kandkhorov to bill all my medical and dental insurances or third party payers and make payments directly to the dentists for services rendered. If check is directly sent to me from my insurance company, I agree to submit check to your office within five (5) days or I will be charged and incurred interest.

________________ By signing below. I agree to have any issues of medical/dental malpractice decided by neutral arbitration and I am giving up my right to a jury or court trial.

________________ Acknowledgment of receipts of Notice of Privacy Practices & Dental Materials Fact Sheet.

PATIENT / GUARANTOR SIGNATURE: X ________________________________ DATE ________________

Dental History

what would you like us to do today? _____ Where are you feeling in dental discomfort today? _____

Former Dentist: _____ Phone: _____ City: _____

Date of last dental care: _____ What treatment? _____ Date of last X-ray: _____

Check ( ) If you have had a problems withany of the following:

Yes	No	Bad breath	Yes	No	Food collection between teeth	Yes	No	Periodontal disease	Yes	No	Sensitivity to sweets
Yes	No	Bleeding gum	Yes	No	Night grinding teeth	Yes	No	sensitivity to cord	Yes	No	sensitivity when biting
Yes	No	Clicking or popping jaws	Yes	No	Loose teeth or broken fillings	Yes	No	sensitivity to hot	Yes	No	Sores or swelling in mouth

How often do you brush? _____ Floss _____ Use electric brush? Brand: _____ How often teeth cleaning? _____

How do you feel about the appearance of your teeth? Happy? _____ Do you want to improve? _____

Have you ever experienced an adverse reaction during our in conjunction with a medical or dental procedure. Yes No

Other information about your dental health our previous treatment. _____

Medical History

Physician's Name: _____ **Phone:** _____ **Date of last visit:** _____

Place a mark on "YES" or "NO" to indicate if you have had any of the following.

AIDS	Yes	No	Epilepsy	Yes	No	Psychiatric care	Yes	No
Anemia	Yes	No	Fainting for dizziness	Yes	No	Radiation treatment	Yes	No
Arthritis , Rheumatism	Yes	No	Glaucoma	Yes	No	Respiratory disease	Yes	No
Artificial heart valves	Yes	No	Headaches	Yes	No	Rheumatic fever	Yes	No
Artificial joints	Yes	No	Heart murmur	Yes	No	Scariet fever	Yes	No
Asthma	Yes	No	Heart problem	Yes	No	Shortness of breath	Yes	No
Back problems	Yes	No	Hepatitis	Yes	No	Sinus trouble	Yes	No
Bleeding abnormally with extraction or surgery	Yes	No	Type_____			Skin rash	Yes	No
			Herpes	Yes	No	Special diet	Yes	No
Blood disease	Yes	No	High blood pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	HIV positive	Yes	No	Swelling of feet or ankles	Yes	No
Chemical dependency	Yes	No	Jaundice	Yes	No	Thyroid problem	Yes	No
Chemotherapy	Yes	No	Jaw pain	Yes	No	Tonsillitis	Yes	No
Circulatory problems	Yes	No	Kidney disease	Yes	No	Tuberculosis	Yes	No
Congenital heart lesions	Yes	No	Liver disease	Yes	No	Tumor or growth on head or neck	Yes	No
Cortisone treatments	Yes	No	Low blood pressure	Yes	No	Ulcer	Yes	No
Cough persistent or bloody	Yes	No	Mitral valve prolapse	Yes	No	Venereal disease	Yes	No
Diabetes	Yes	No	Nervous problem	Yes	No	Weight loss		
Emphysema	Yes	No	Peacemaker	Yes	No	Unexplained	Yes	No
Do you wear contact lens	Yes	No	Women			Smoke	Yes	No
			Are you pregnant ?	Yes	No			
			Taking birth control pills ?	Yes	No			
			Are you nursing?	Yes	No			

MEDICATION	ALLERGIES
List medication you are currently taking _____ _____ Have you ever taken Fen-Phen? Yes No Have you ever taken Redex? Yes No	Aspirin Barbiturates (Sleeping Pills) Codeine Iodine Latex Local Anesthetic Penicillin Sulfa Other _____ _____

DATE	PATIENT'S/PARENT'S SIGNATURE	BP/P	DOCTOR'S SIGNATURE

MEDICAL UPDATES (to be filled in once a year)

I have reviewd my Health History and confirm that it accuratly states past and present conditions.

Date	PATIENT SIGNATURE	CHANGE TO HEALTH HISTORY	DENTIST INITIALS

DENTAL SERVICES AGREEMENT

_____ and the undersigned _____ have agreed as follows:

ARTICLE 1: IT IS UNDERSTOOD THAT ANY DISPUTE AS TO DENTAL MALPRACTICE THAT IS AS TO 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 CONTRACT. 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: In the event of any claim, demand,controversy or dispute the essential nature of which involves injury, malpractice, any tort by patient, his dependents, whether or not minors, heirs at law or personal representatives against Doctor or any doctor's offices, directors, shareholders, agents,representatives,employees, successors in interest, assigns or associates agreeing in writing to be bound by the arbitration provisions of this agreement ("Affiliates"). **THE SOLE METHOD OF RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION IN ACCORDANCE WITH THE COMMERCIAL ARBITRATION RULES OF THE AMERICAN ARBITRATION ASSOCIATION.** The parties hereby agree that they shall submit their controversy to an Arbitrator who is a dentist licensed in California. Such arbitrator shall be acceptable to both parties. Notwithstanding the foregoing,two additional Arbitrators who are dentists may be added by the parties by agreement in writing to create an arbitration panel of three. It is agreed that all parties relevant to a full and complete settlement of dispute subject to this agreement may be intervened or joined.

ARTICLE 3: The prevailing party in an arbitration pursuant to this agreement shall be awarded all costs including reasonable attorneys fees and the arbitrators' fees,in prosecuting or defending the claim in arbitration,but not to exceed$5,000 in amount. Furthermore,if an action is undertaken to set aside or otherwise attack the binding arbitration award, the losing party in the court action shall bear all the prevailing party's costs including reasonable attorneys fees.

ARTICLE 4: Any party initiating arbitration under this agreement shall file with his petition a bond or cash surety in amount equal to five hundred dollars ($500).which shall provide security for attorney's fees and costs in the event that the moving party shall not prevail.

ARTICLE 5: This agreement shall govern all future services rendered to patient by Doctor and Doctor's Affiliates and associates. Execution of this agreement is a precondition to the furnishing of services by Doctor,but this agreement may be rescinded by either party within thirty days of signature. After those thirty days,this agreement may be changed or revoked only by a written revocation signed by both parties.

ARTICLE 6: 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 other than the treating dentist is responsible for the treatment being rendered to me.

ARTICLE 7: Doctor hereby agrees to render dental care and services to patient. Patient agrees to pay Doctor promptly upon the rendering of a bill at the currently prevailing rate,or to cooperate with doctor in obtaining payment from third party payers.

ARTICLE 8: Expect for that Doctor has indicated professional services will not be rendered to patient unless this agreement is executed. Doctor has made no other representations or statements oral or written to induce patient to execute this agreement.

ARTICLE 9: In the event that any provision of this agreement shall be void or unenforceable for any reason wheelchair,then such provision shall be stricken and of no force and effect. The remaining provisions of this agreement, however, shall continue in full force and effect and to the extent required shall be modified to preserve their validity. This agreement shall be governed by California law.

This is a binding legal document which may have an important effect on your legal rights. Consult your attorney on any question you may have.

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 COURT TRIAL. SEE ARTICLE 1 TO THIS CONTRACT

_____
(PATIENT'S SIGNATURE)

_____
(TRANSLATED BY)

_____
(PATIENT'S AGENT OR REPRESENTATIVE)

_____
(RELATIONSHIP TO THE PATIENT)

_____
(DATE)

_____
(OFFICE REPRESENTATIVE)

DENTAL TREATMENT CONSENT FORM

Please read and initial the checked below
And read and sign the bottom of this form.

Patient Name _____

( ) 1. WORK TO BE DONE
I understand that I am having the following work done. X-rays and exam and/or prophylaxis _____ Fillings _____

Date _____ Initials _____

( ) 2. CHANGE IN TREATMENT
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 examinations, the most common being root canal therapy, following routine restorat procedures. I give my permission to the dentist to make any/all changes or additions necessary.

Date _____ Initials _____

( ) 3. REMOVAL OF TEETH
Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) I authorize this dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3.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 (parathesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalizations arise during or following treatment,the cost of which is my responsibility.

Date _____ Initials _____

( ) 4. CROWNS AND BRIDGES
I understand that sometimes it is not possible to match the color of natural with artificial teeth. I further understand that I may 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 cap (including shape, fit, size and color) will be before final cementation.

Date _____ Initials _____

( ) 5. ENDODONTIC TREATMENT (ROOT CANAL THERAPY)
I realize that there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

Date _____ Initials _____

( ) 6. PERIODONTAL LOSS (TISSUE & BONE)
I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternate treatment plans have been explained to me,including gum surgery,replacement and/or extraction. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Date _____ Initials _____

( ) 7. I acknowledge that I have received from the dentist a copy of the Dental Materials Fact Sheet dated October 2001.

Signature of patient/parent _____ Date _____

I understand that dentistry is not an exact science and that,therefore,reputable practitioners cannot fully 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 have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of patient/parent _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____

Doctor Signature _____ Date _____

DENTAL TREATMENT CONSENT FORM

Please read and initial the checked below
And read and sign the bottom of this form.

Patient Name _____

( ) 7. DRUGS AND MEDICATIONS
I understand the antibiotics and analgesics and other medications. Date _____ Initials _____

( ) 8. DENTURES,COMPLETE OR PARTIAL
I realize that full or partial dentures are artificial,constructed of plastic,metal and/or porcelain. The problem of wearing these appliances have been explained to me,including looseness,soreness,and possible breakage. I realize the final opportunity to make changes in my new dentures(including shape,fit,size,placement and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not include in the initial denture fee.

Date _____ Initials _____

( ) 9. PERSONAL HEALTH INFORMATION AND PRIVACY(HIPAA)
I understand that this office will not use my personal health information,including social security number,date of birth,phone number,for any other purpose other than billing or dental treatment. Furthermore,I understand that a copy of this doctors "**NOTICE OF PRIVACY PRACTICES**" has been made available to me. I also understand that I have important rights relating to inspecting and copying my medical information that the doctor maintains,amending or correcting that information,and obtaining an accounting of the doctor's disclosures. I also have the right to request this doctor to communicate with me should a request for my personal health information be made from anyone other than me. I understand that if I have any concerns or complains about how my personal health information is handled I may contact _____ at this office. I give this office my written consent to disclose my personal health information for purposes of health care,the payment for or reimbursement of the care provided to me and the related administrative activities supporting my treatment.

Signature of Patient _____ Date _____

Signature of Parent/Guardian if patient is a minor _____ Date _____

Doctor Signature _____ Date _____