ITC Dental
Implant Center & General Dentistry

PATIENT INFORMATION

Date: _____

SS/Patient ID: _____

First Name: _____

Last Name: _____

Middle Initial : _____

Address : _____

City: _____

State: _____Zip: _____

E-Mail: _____

Sex: ☐ M ☐ F Age: ____ Birth date: _____

☐ Married ☐ Single ☐ Minor ☐ Other

Occupation : _____

Employer/School: _____

Employer/School Address: _____

_____

PHONE NUMBERS

Home: ( )_____ Cell: ( )_____

Pharmacy: _____ Phone: ( ) _____

Location: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship: _____

Home Phone: ( )_____

Work Phone: ( )_____ Cell: ( ) _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Co.: _____

Member ID _____

Group #: _____

Subscriber's Name: _____

Birth Date: _____ SS#: _____

Is patient covered by additional insurance? _____ Yes ____ No

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____

Name of Insurance Company (ies)

And assign directly to Dr. Ivan Teran Casabianca all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my healthcare information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This content will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Beneficiary, Guardian or Personal Representative

_____

Please Print Name of Beneficiary, Guardian or Personal Representative

Date: _____ Relationship to Beneficiary: _____

PREVIOUS DENTIST

Previous Dentist name: _____ Phone Number: ( )_____

Last dental exam: _____ Last Dental Cleaning: _____

Comments/Concerns for today's visit:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or dental insurance coverage. It is my responsibility to be aware of my eligibility and coverage with the above named insurance Company, and I understand that my dental insurance may only provide coverage for only the minimum standard of care. I elect to follow Dr. Teran's recommendations for optimal dental treatment. I understand that ITC Dental is confirming my dental benefits and billing my insurance for treatment as a courtesy, and declined claims for payment will become patient responsibility.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Please Print Name of Patient, Guardian or Personal Representative **Relationship To Patient**

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MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	☐ Yes	☐ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	☐ Yes	☐ No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	
Have you ever taken Fosamax, Bovina, Actonel, or any other medications containing bisphosphonates?	☐ Yes	☐ No	
Are you on a special diet?	☐ Yes	☐ No	
Do you use tobacco?	☐ Yes	☐ No	
Do you use controlled substances?	☐ Yes	☐ No	

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs
☐ Other, if yes please explain: _____ _____
☐ None or None known

Women:
☐ Pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Do you have, or have you had, any of the following?

AIDS/HIV	☐Yes	☐No	Cortisone Medicine	☐Yes	☐No	Hemophilia	☐Yes	☐No	Radiation Treatments	☐Yes	☐No
Alzheimer's Disease	☐Yes	☐No	Diabetes	☐Yes	☐No	Hepatitis A	☐Yes	☐No	Recent Weight Loss	☐Yes	☐No
Anaphylaxis	☐Yes	☐No	Drug Addiction	☐Yes	☐No	Hepatitis B/C	☐Yes	☐No	Renal Dialysis	☐Yes	☐No
Anemia	☐Yes	☐No	Easily Winded	☐Yes	☐No	Herpes	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Angina	☐Yes	☐No	Emphysema	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Rheumatism	☐Yes	☐No
Arthritis/Gout	☐Yes	☐No	Epilepsy or Seizures	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Artificial Heart Valve	☐Yes	☐No	Excessive Bleeding	☐Yes	☐No	Hives or Rash	☐Yes	☐No	Shingles	☐Yes	☐No
Artificial Joint(s)	☐Yes	☐No	Excessive Thirst	☐Yes	☐No	Hypoglycemia	☐Yes	☐No	Sickle Cell Disease	☐Yes	☐No
Asthma	☐Yes	☐No	Fainting Spells/Dizziness	☐Yes	☐No	Irregular Heartbeat	☐Yes	☐No	Sinus Trouble	☐Yes	☐No
Blood Disease	☐Yes	☐No	Frequent Cough	☐Yes	☐No	Kidney Problems	☐Yes	☐No	Spina Bifida	☐Yes	☐No
Blood Transfusion	☐Yes	☐No	Frequent Diarrhea	☐Yes	☐No	Leukemia	☐Yes	☐No	Stomach Disease	☐Yes	☐No
Breathing Problem	☐Yes	☐No	Frequent Headaches	☐Yes	☐No	Liver Disease	☐Yes	☐No	Stroke	☐Yes	☐No
Bruise Easily	☐Yes	☐No	Genital Herpes	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Swelling of Limbs	☐Yes	☐No
No Cancer	☐Yes	☐No	Glaucoma	☐Yes	☐No	Lung Disease	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Chemotherapy	☐Yes	☐No	Hay Fever	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	Tonsillitis	☐Yes	☐No
Chest Pains	☐Yes	☐No	Heart Attack/Failure	☐Yes	☐No	Osteoporosis	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Cold Sores/Fever Blisters	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Pain in Jaw Joints	☐Yes	☐No	Tumors or Growths	☐Yes	☐No
Congenital Heart Disorder	☐Yes	☐No	Heart Pacemaker	☐Yes	☐No	Parathyroid Disease	☐Yes	☐No	Ulcers	☐Yes	☐No
Convulsions	☐Yes	☐No	Heart Trouble/Disease	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	Venereal Disease	☐Yes	☐No
									Yellow Jaundice	☐Yes	☐No

Have you had any other serious illness not mentioned above? _____

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

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____ DATE _____

SIGNATURE OF DOCTOR _____

PATIENT NAME: _____ BIRTH 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: _____ DATE: _____

SIGNED: _____ SIGNED: _____

Patient/Legal Guardian (Witness)

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25272 MCINTYRE STE D | LAGUNA HILLS CA, 92653 | (949) 460-0041

Financial Policy

Thank you for choosing ITC Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Options[1] from Care Credit Healthcare Credit Card
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

ITC Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if this occurs. For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

ITC Dental charges $30 for returned checks

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

[1]Subject to credit approval

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HIPAA Notice of Privacy Practice and Dental Materials Fact Sheet

The Health Insurance Portability and Accountability Act (HIPAA) requires that healthcare providers give each patient a copy of the Notice of Patient Privacy Practices and Dental Materials Fact Sheet, and make a good faith effort to obtain acknowledgement of receipt for the notice. Patient may refuse to sign for receipt.

By signing this form, I confirm that I have received a copy of the Notice of Privacy Practice and a copy of the Dental Materials Fact Sheet.

Patient or Parent/Guardian Name: _____

Patient or Parent/Guardian Signature: _____Date: _____

OFFICE USE:

Written acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Unable to communicate with patient
- ☐ Emergency situation_____
- ☐ Other_____

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GENERAL INFORMED CONSENT

1. EXAMINATION AND X-RAYS:
   I understand that the initial/periodic visit will require radiographs in order to complete the examination, diagnosis, and treatment plan. I hereby, give my consent to take x-rays. (Initials_____)

2. DRUGS , MEDICATION, AND SEDATION:
   I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
   (Initials_____)

3. CHANGES IN TREATMENT PLAN:
   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 examination, with the most common being root canal therapy following routine restorative procedures. (Initials_____)

4. TEMPRO-MANDIBULAR 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 in 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_____)

5. DENTAL PROPHYLAXIS (CLEANING):
   I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums, and is limited to the removal of plaque and extremely light tarter & stain from the tooth in the absence of periodontal (gum) disease. This treatment prevents gingivitis and gum disease.
   (Initials_____)

6. DEBRIDEMENT (CLEANING):
   I understand that this type of cleaning is preventative in nature and intended for clients with gingivitis (inflamed & bleeding gums) and is for the removal of heavy build up of tarter and stain from the tooth structures in the absence of periodontal (gum) disease. This treatment prevents gum disease.
   (Initials_____)

7. DENTAL INSURANCE BENEFITS:
   I understand that my dental insurance may only provide coverage for only the minimum standard of care. I elect to follow Dr. Teran's recommendations for optimal dental treatment. I understand that ITC Dental is confirming my dental benefits and billing my insurance for treatment as a courtesy, and declined claims for payment will become patient responsibility.
   (Initials_____)

Patient Signature_____Date _____

Doctor Signature _____ Date_____