CAPITAL DENTAL GROUP

PATIENT ACCT#_____

PATIENT INFORMATION

LAST NAME		FIRST	MI
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		CELL PHONE	
EMAIL ADDRESS			
SOCIAL SECURITY NO.			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
FULL TIME STUDENT? NAME OF SCHOOL			
EMPLOYER NAME			
EMPLOYER PHONE NO.			

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT, IF OTHER THAN YOU

NAME	DATE OF BIRTH
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.
PHONE NO.	WORK PHONE NO.

SPOUSE INFORMATION

NAME	DATE OF BIRTH
EMPLOYER NAME	
EMPLOYER PHONE NO.	

PERSON TO CONTACT FOR EMERGENCY

NAME:	RELATIONSHIP
PHONE NO.	

NEAREST RELATIVE NOT LIVING WITH YOU

NAME:	RELATIONSHIP
PHONE NO.	

DENTAL INFORMATION

PRIMARY INSURANCE CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP
INSURED'S I.D. NO.	

SECONDARY INSURANCE CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP
INSURED'S I.D. NO.	

HOW DID YOU HEAR ABOUT OUR OFFICE

- ☐ FAMILY/ FRIEND REFERRAL
- NAME OF PERSON:_____
- ☐ INSURANCE LIST ☐ RADIO
- ☐ YELLOW PAGES ☐ SAW BUILDING
- ☐ TV-IMPLANTS ☐ TV AD
- ☐ IMPLANT INFOMERCIAL (WELLNESS HOUR)
- ☐ OTHER: _____

Open 7 days a week!

(661) 861-8000

Patient / Responsible person signature: _____ **Date:** _____

8701 CAMINO MEDIA, SUITE A. BAKERSFIELD, CA 93311 (661) 861-8000 www.capitaldentalgroup.com

CAPITAL DENTAL GROUP

MEDICAL HISTORY FORM

last updated 06/09/2019

Patient Name _____

Patient Date of Birth _____

Check if allergic to: ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Sulfa ☐Drugs ☐Local Anesthetic

Other allergies: _____ List any previous reactions to local anesthetic, metals, or sedation: _____

☐Yes ☐No Are you under a physician's care now? If yes, explain: _____

List any prescribed medications you are taking: _____

List any over the counter medications you are taking: _____

☐Yes ☐No Have you had a serious head or neck injury?

☐Yes ☐No Do you take/have taken Phen-Fen or Redux?

☐Yes ☐No Have you taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates?

☐Yes ☐No Do you use tobacco? List any recreational drug use: _____

☐Yes ☐No Is pre-medication required before dental visits?

☐Yes ☐No Do you snore loudly?

☐Yes ☐No Do you often feel tired, fatigued, or sleepy during the day?

☐Yes ☐No Do you stop breathing or wake up choking or gasping during your sleep?

☐Yes ☐No Is your percentage of body fat 10% higher than standard?

☐Yes ☐No Do you have high blood pressure?

☐Yes ☐No Have you been diagnosed with any sleep disorders? If yes, explain: _____

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

☐Abnormal Blood Pressure ☐High ☐Low	☐Blood Transfusion	☐Glaucoma	☐Mitral Valve Prolapse
☐AIDS/ HIV Positive	☐Cancer _____ _____	☐Heart Problems _____ _____ _____	☐Organ Transplant
☐Alzheimer's Disease	☐Chemotherapy		☐Radiation Therapy
☐Anemia	☐Congenital Heart Disease	☐Hemophilia	☐Shingles
☐Artificial Heart Valve	☐Diabetes	☐Hepatitis ☐A ☐B ☐C	☐Sickle Cell Disease
☐Artificial Joint	☐Epilepsy or Seizures	☐High Cholesterol	☐Sleep Apnea
☐Asthma/Breathing Problems	☐Excessive Bleeding	☐Kidney Problems	☐Stroke
☐Autism Spectrum Disorder	☐Fainting/ Dizziness	☐Liver Disease	☐Thyroid Disease
			☐Tuberculosis

List any other serious illness not mentioned above: _____

Comments/ concerns we should be aware of: _____

_____

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 changed in my medical status.

Signature: _____ Relationship to patient: _____ Date: _____

Doctor/ back office use

*PATIENT ACCT #*_____

CAPITAL DENTAL GROUP

Office Financial Policies and Authorizations

1. I hereby authorize 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.

2. I agree 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.

3. It is the patients' responsibility to provide CDG with up to date insurance information at the time of each visit. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of my insurance coverage or payment. Patient understands that all services rendered by our office will be reported for payment to the patient's applicable insurance company unless the patient submits a written request at the time of service for requested services not to be reported to insurance. Patient understands that all prosthetic fees are incurred at the time the prosthetic has been initialized. Therefore; if the prosthetic is not delivered to the patient due to non-compliance, the patient is responsible for the full fees incurred.

4. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a monthly late fee of $3.00 will be added to my account.

5. In the event I am dissatisfied with my treatment, I agree to have any dispute adjudicated by the Peer Review Board.

6. I also understand that appointments not cancelled with a minimum of 48 hours notice, may be subject to a $25 broken appointment fee.

7. I acknowledge I have received or have had an opportunity to review a copy of the Dental Materials Fact Sheet dated October 2001.

Patient / Responsible person (printed) _____

Signature _____ Date _____

Witnessed by _____ Date _____

*PATIENT ACCT #*_____

CAPITAL DENTAL GROUP

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, D.D.S., Wade Logan, D.D.S., Stephen Wilson, D.D.S., and Scott Dahlquist, D.D.S.

Patient's Freedom of Choice

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 listed above. The following facilities provide dental computerized axial tomography scans within twenty-five miles of this office:

James N. Clark, D.D.S.
1805 28th Street
Bakersfield, CA 93301
661-325-5751

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

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

Stanley S. Koh, D.D.S., Inc.
3301 19th Street, Suite B
Bakersfield, CA 93301
661-327-2051

Truxtun Radiology Medical Group
(for implants only)
4000 Empire Drive, 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 Street, Suit 1550, Sacramento, CA 95815.

I hereby acknowledge receipt of this notice.

Patient's Name: _____ **Date:** _____

Patient's Signature: _____

*PATIENT ACCT #*_____

CAPITAL DENTAL GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I give consent to the doctor's or designated staff's 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 and that a notice fully outlining the protection of my personal health information is available (HIPAA Act).

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 a spouse or family member call us for healthcare information pertaining to you from our office.

Please list designee recipients who can obtain this information:

Name of designee	**Relationship**	**Date of birth**
Name of designee	**Relationship**	**Date of birth**

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

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, Suite A, Bakersfield, CA 93311.**

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, ore eligibility for benefits.

_____ _____

Signature of Patient or Patient's Personal Representative **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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

Patient ID #_____

Capital Dental Group's
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.

By: _____ Date: _____
Patient's or Patient Representative's Signature

Print Patient's Name: _____

If Representative, Print Name and Relationship to Patient:

_____

_____ Date: _____
Dentist's or Authorized Representative's Signature

A signed copy of this document is to be given to Patient. Original is to be filed in Patient's medical/dental records.