Dr. Mirta E. Simanian
23107 Lyons Ave
Newhall, CA 91321

Confidential Information

Full Name _____ Phone _____ Marital Status _____

Home Address _____ City _____ Zip Code _____

Drivers License # _____ Social Security # _____ Birth Date _____

In case of Emergency Contact _____ Phone _____

How did you hear about us? _____

Email Address _____

Dental Insurance _____

When was your last visit to a dentist? _____ Reason for that visit? _____

Medical History

Are you in good health? [ ] Yes [ ]No

Are you under medical care? [ ] Yes [ ]No

Are you under any medication? [ ] Yes [ ]No

If yes, what medication? _____

Any existing heart condition? [ ] Yes [ ] No

High Blood Pressure? [ ] Yes [ ] No

Diabetic? [ ] Yes [ ] No

Rheumatic Fever? [ ] Yes [ ] No

Tuberculosis? [ ] Yes [ ] No

Asthma? [ ] Yes [ ] No

Hepatitis/Jaundice? [ ] Yes [ ] No

Arthritis? [ ] Yes [ ] No

Allergies? [ ] Yes [ ] No

Bleeding Problems(Hemophilia)? [ ] Yes [ ]No

Artificial Joint? [ ] Yes [ ] No

Prosthetic Value? [ ] Yes [ ] No

Have you ever taken any of the following: [ ] Yes [ ] No

Phen Phen ___ Boniva ___ Fosamax ___ Reclast _____

Have you had any reactions to: _____

Penicillin(Antibiotics)? [ ] Yes [ ] No

Sulfa? [ ] Yes [ ]No

Anesthetics, Such as Novocain? [ ] Yes [ ] No

Aspirin? [ ] Yes [ ] No

Others: _____

Any other medical conditions? [ ] Yes [ ] No

If yes, please explain: _____

Epilepsy? [ ] Yes [ ] No

Communicable Disease(AIDS)? [ ] Yes [ ] No

Are you pregnant? [ ] Yes [ ] No

If yes, how many months? _____

Name and phone number of physician? _____

( ) _____

Dental History

Do you have: _____

Tender teeth? [ ] Yes [ ] No

Bleeding Gums? [ ] Yes [ ] No

Bad breath? [ ] Yes [ ] No

Sore Spots? [ ] Yes [ ] No

Pain in TMJ? [ ] Yes [ ] No

Sensitivity to Hot or Cold? [ ]Yes [ ] No

Spaced Teeth? [ ]Yes [ ] No

Have you ever been treated by: _____

Orthodontist? [ ]Yes [ ] No

Periodontist? [ ]Yes [ ] No

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Arbitration Agreement

Article 1
It is understood that any dispute as to dental/medical malpractice, that is as to whether any dental/medical 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 right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2
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 the Agreement includes the undersigned Doctor and his or her professional corporation or partnership, all independent contractors who practice dentistry at the undersigned Doctors place of business, and any employees agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities. The Doctor 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.
B) Treatment Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Doctor and Patient will be subject to compulsory, binding arbitration.
C) Other Doctors (if Applicable). Patients understands that he or she may at times receive treatment from one or more Doctors who are independent contractors practicing at the same facility as the undersigned Doctor. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such Doctors practicing at the same facility as the undersigned Doctor will be subject to compulsory, binding arbitration.
D) Coverage of Prenatal Claims (if Applicable). Patient understands and agrees that, if Doctor treats her during pregnancy, any dispute of the sort described in Article 1 as to (medical/dental) treatment which is claimed to have affected the unborn child will be subject to compulsory, binding arbitration.

Article 3
a) Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the medical/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 of the statute of limitations for 90 days.
b) Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement within 10 days of the expiration of the 90 days, Patient shall notify Doctor in writing of his or her desire to arbitrate and shall designate an arbitrator. Within 20 days of receipt of such notice, Doctor will designate an arbitrator to act on Doctor's behalf. In this event that more than two parties participate, all plaintiffs agree on one arbitrator, all defendants agree on one arbitrator and those arbitrators select a neutral arbitrator. The controversy shall than be submitted to the three arbitrators for a final and binding decision.
c) Applicable Law The arbitration shall be conducted pursuant to the California Arbitration Act. (C.C.P 1280-1295.) The arbitrators shall, in addition, have authority to order such other discovery as they deem 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 of 1975 which shall apply to the same extent as if the dispute were pending before a superior court of this State.
d) Interpretation of Agreement. Any controversy concerning the interpretation or application of the Agreement itself shall also be submitted to arbitration in the manner provided above.

Article 4
Revocation. If you sign this Agreement and then change your mind, the law permits you to revoke the Agreement, providing you give your Doctor written notice within 30 days from signing that you want to withdraw from the Agreement. However, Doctor and Patient agree that any claim arising from dental/medical services rendered prior to revocation shall be subject to arbitration.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL/DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL.SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature _____ **Date** _____

HIPPA CONSENT FORMS

Golden Oak Dental
23107 Lyons Ave
Newhall, CA 91321

Patient Name: _____

HIPPA Notice of Privacy Practice

HIPPA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Montage Cosmetic Dental may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPPA Regulations. Though Montage Cosmetic Dental has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPPA Privacy Rule to Distribute this notice to you and obtain acknowledgement that you have received the Notice. Signing below indicated that you have received the Notice of Privacy Practice.

Initials _____

Insurance
All professional services rendered are charged to the patient. Necessary forms will be completed by Montage Cosmetic Dental to help expedite insurance carrier's payments. However, the patient is responsible for all fees regardless of the insurance company.

Initials _____

I understand my signature authorizes releasing of the information to the insurer or agency given to Montage Cosmetic Dental for participating health insurance plans.

Patient Signature _____ Date _____

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Office Policies

Please read and sign the following:

Payments

Payment in full is due at the time of service. We offer several options of payments for the service we provide. We accept cash, checks, Visa, MasterCard, Discover, American Express, and Care credit.

Initial _____

Missed appointment

One of the ways we keep our fees more affordable is by avoiding broken appointments. We understand that occasionally our patients will need to reschedule their appointments. Please notify us 48 hours prior to your appointment to avoid a charge. ***Broken appointment fees without 48 hour notice are $75 or more depending on your insurance policies.***

Initial _____

Service charge

We will charge a $50 fee for any returned checks. Fee incurred to collect payments will be billed to and payable by the patient or responsible party.

Initial _____

Signature _____ Date _____