OC DENTAL CENTER
General Cosmetic & Orthodontics
Adults & Children

PATIENT INFORMATION

PATIENT

Name _____ (Last) _____ (First)
Address _____ Apt. # _____
City _____ Zip _____
How long in this address? _____
Phone ( ) _____ Cell o Pager ( ) _____
E-mail _____
Social Security # _____ DL# _____
Age _____ Birthdate _____

RESPONSIBLE PARTY (if same as above, please skip)

Name _____ (Last) _____ (First)
Address _____ Apt. # _____
City _____ Zip _____
How long in this address? _____
Phone ( ) _____
Social Security # _____
Relatonship to Patient _____
Age _____ Birthdate _____

EMPLOYMENT

Occupation _____
Employer _____
How Long? _____
Business Address _____
City _____ Zip _____
Phone ( ) _____ Ext. # _____
Verified By _____ (Office use only) **Date** _____

REFERENCES

Name _____ (Last) _____ (First)
Address _____ Apt. # _____
City _____ Zip _____
Phone ( ) _____
Name _____ (Last) _____ (First)
Address _____ Apt. # _____
City _____ Zip _____
Phone ( ) _____
Spouses Name _____ (Last) _____ (First)
Spouses Work Phone ( ) _____

PERSON TO CONTACT FOR EMERGENCY

Name _____ (Last) _____ (First)
Address _____ Apt. # _____
City _____ Zip _____
Phone ( ) _____
Physician Name _____
Phone ( ) _____

GETTING TO KNOW YOU

Are there other members of your household who are not patients at our office?
YES ☐ NO ☐ Please list names & relationship (son, daughter, husband) below:

1. _____ 2. _____
3. _____ 4. _____

How do you hear of us?
_____

Are you or anyone in your family a Union member? YES ☐ NO ☐
If yes, specify Union/Local: _____

I want information in Spanish: YES ☐ NO ☐

INSURANCE Primary Insurance Company

Name _____
Address _____
City _____ Zip _____
Insurance Co. Phone ( ) _____
Employer _____
Union/Local _____ Group # _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birthdate _____

INSURANCE Primary Insurance Company

Name _____
Address _____
City _____ Zip _____
Insurance Co. Phone ( ) _____
Employer _____
Union/Local _____ Group # _____
Insured's Name _____
Insured's Soc. Sec. # _____ Birthdate _____

MANAGED CARE PLAN (HMO)

Plan Name _____ Group # _____ Plan _____
Employer _____

1. **I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.**
2. **By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.**
3. **I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.**
4. **I understand that OC Dental / P. Sabo DDS, INC. provides business support services to independent dentists and recognize that this dental practice is operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist nor OC Dental / P. Sabo DDS, INC. is responsible for my dental**

_____
Signature of responsible party or patient (Parent if patient is a minor) Date

OC DENTAL CENTER

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GENERAL HEALTH INFORMATION

Date: _____

Patient Name: _____ Birth Date: _____ Age: _____
LAST NAME

DENTAL HISTORY

1. Are there other conditions of which we should be aware? YES❑ NO❑ If yes, please specify: _____

2. Why are you here today? Check-Up _____ Cleaning _____ Other _____
Toothache _____ Chief Complaint _____

3. When did you last visit a dentist? _____ 4. What treatment was performed? _____

5. Was the treatment completed? _____ 6. Did you have a cleaning? _____

7. When were dental x-rays taken? _____

8. Have you ever had prolonged bleeding atter an extraction? YES❑ NO❑ If yes, please specify: _____

9. Have you had any problems with past dental treatment? YES❑ NO❑ If yes, please specify: _____

10. Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain or locking open?
YES❑ NO❑ If yes, please specify: _____

11. Have you ever been diagnosed or treated for TMD (Temporomandibular joint Dysfunction sometimes called TMJ)?
YES❑ NO❑ If yes, please specify: _____

12. Do your gums bleed easily YES❑ NO❑

13. Do you feel you have bad breath? YES❑ NO❑

14. Are your teeth sensitive to hot or cold? YES❑ NO❑

15. Would you like your teeth whiter? YES❑ NO❑

16. Are there any cosmetic changes you would like to have done on your teeth? YES❑ NO❑ If yes, please specify: _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES❑ NO❑ If yes, please specify: Dr. Name _____ Dr. Ph # _____

2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____

3. Are you taking any medications at this time, including birth control? YES❑ NO❑ If yes, please specify: _____

4. (Woman) Are you pregnant at this time? YES❑ NO❑ If yes, please specify how many months: _____

5. Are there any other health problems of which we should be advised? Please specify: _____

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

Please check "YES" or "NO"		Doctor Comments
ARTIFICIAL Heart valve	YES❑ NO❑	
AIDS/HIV+	YES❑ NO❑	
ANEMIA	YES❑ NO❑	
ANGINA	YES❑ NO❑	
ARTHRITIS	YES❑ NO❑	
ASTHMA	YES❑ NO❑	
BLEEDING PROBLEMS	YES❑ NO❑	
CANCER	YES❑ NO❑	
CHEMO/RAD THERAPY	YES❑ NO❑	
COSMETIC SURGERY	YES❑ NO❑	
DIABETES	YES❑ NO❑	
DIZZY SPELLS	YES❑ NO❑	
DRUG ADDICTION	YES❑ NO❑	
EMPHYSEMA	YES❑ NO❑	
EPILEPSY	YES❑ NO❑	
FAINTING	YES❑ NO❑	
GLAUCOMA	YES❑ NO❑	
HEART ATTACK	YES❑ NO❑	
HEART SURGERY	YES❑ NO❑	
HEART MURMUR	YES❑ NO❑	

Please check "YES" or "NO"		Doctor Comment
HEART PROBLEMS	YES❑ NO❑	
HEPATITIS	YES❑ NO❑	
HIGH BL.PRESSURE	YES❑ NO❑	
JAUNDICE	YES❑ NO❑	
JOINT PROSTHESIS	YES❑ NO❑	
KIDNEY DISEASE	YES❑ NO❑	
LATEX ALLERGY	YES❑ NO❑	
LIVER PROBLEMS	YES❑ NO❑	
LOW BL.PRESSURE	YES❑ NO❑	
LUNG DISEASE	YES❑ NO❑	
PACEMAKER	YES❑ NO❑	
PHEN-FEN	YES❑ NO❑	
PSYCHIATRIC CARE	YES❑ NO❑	
RHEUMATIC FEVER	YES❑ NO❑	
SINUS TROUBLE	YES❑ NO❑	
SMOKING TOBACCO	YES❑ NO❑	
STROKE	YES❑ NO❑	
THYROID PROBLEMS	YES❑ NO❑	
TMD OR TMJ	YES❑ NO❑	
TUBERCULOSIS	YES❑ NO❑	
VENEREAL DISEASE	YES❑ NO❑	

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

Patient's signature _____ Date _____
(or Parent if patient is a minor)

Doctor's Signature _____

RECALL REVIEW:

1. Patient's Signature _____ Doctor's Signature _____ Date _____

2. Patient's Signature _____ Doctor's Signature _____ Date _____

DOCTOR-PATIENT ARBITRATION AGREEMENT

ARTICLE 1: **Agreement to Arbitrate:** It is understood that any dispute as to dental malpractice, that is as to whether any dental services rendered under this contact were unnecessary or unauthorized or were improperly, negligent or incompletely rendered, will be determined by submission to arbitration as provided by California State law, and not by 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.

ARTICLE 2: **All claims must be Arbitrated:** 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 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 mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdiction 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 an 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.

ARTICLE 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. The parties shall agree to an arbitrator within thirty days. In the event that the parties are unable to agree to an arbitrator, each party shall select an arbitrator and a third arbitrator shall be selected by the arbitrators appointed by the parties. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel feels or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have 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.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrators.

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.

ARTICLE 4: **General Provisions:** 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 of notice thereof, is received, and the claim, if asserted in a civil action, would be barred by the 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.

ARTICLE 5: **Revocation:** 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 at any time for any condition.

ARTICLE 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is 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.

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 A NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____
Doctor's Signature

_____
Print/Stamp Name of Dentist

_____
(If representative, Print Name and Relationship to Patient)

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DENTAL SERVICES AGREEMENT

_____ ("Doctor"), and the undersigned patient ("Patient") 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 WERE IMPROPERLY, NEGLIGENTLY OR INCOMPLETELY 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 OR ARBITRATION PROCEEDINGS, BOTH PARTIES TO THIS 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 personal injury, malpractice or any tort, by Patient, his dependents, whether or not minors, heirs at law or personal representatives against Doctor or any of Doctor's officers, directors, shareholders, agents, representatives, employees, successors in interests, assigns or associates agreeing in writing to be bound by the arbitration provisions of this agreement ("Affiliates"). THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION in accordance with 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. In the event that the parties cannot agree upon a sole Arbitrator, each party shall pick an Arbitrator who is a licensed Dentist in California and the two Arbitrators shall pick a third Dentist proceeding under the rules of the American Arbitration Association. Not withstanding 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 any dispute subject to this agreement may be intervened or joined

ARTICLE 3. The prevailing party in any arbitration pursuant to this agreement shall be awarded all costs, including reasonable attorneys' fees and the Arbitrators' fees, in prosecuting or defending that claim in arbitration, but not to exceed $5,000 in amount. Furthermore, if any 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 an amount equal to Five Hundred Dollars ($500) which shall provide security for attorneys' 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 written notice 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 or other treating Dentist nor OC Dental is responsible for my treatment.

ARTICLE 7. Doctor hereby agrees to render dental care and service to Patient. Patient agrees to pay Doctor promptly upon rendering of a bill at the current prevailing rates, or to cooperate with Doctor in obtaining payment from third party payors.

ARTICLE 8. Except for the fact 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 whatsoever, 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 OF YOUR LEGAL RIGHTS. CONSULT YOUR ATTORNEY ON ANY QUESTIONS YOU MAY HAVE.

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

_____
(PATIENT'S SIGNATURE)

_____
(PATIENT'S AGENT OR REPRESENTATIVE)

_____
(RELATIONSHIP TO PATIENT)

_____
(DOCTOR)

DATE OF SIGNING_____

_____ AM/PM

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING DENTAL INFORMATION

The privacy of your dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our dental office. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share dental information about you. We also describe your rights and certain duties we have regarding the use and disclosure of dental information. Throughout this notice we refer to your medical information as dental information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your dental information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your dental information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all dental information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR DENTAL INFORMATION

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted ways we are permitted to use and disclose dental information. We will not use or disclose your dental information for any information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your dental information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your dental information.

LAW ENFORCEMENT: Under certain circumstances, we may disclose dental information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

APPOINTMENT REMINDERS: We may use and disclose dental information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

ALTERNATIVE AND ADDITIONAL DENTAL SERVICES: We may use and disclose dental information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

FOR HEALTH CARE OPERATIONS: We may use and disclose your dental information for our health care operations. This might include measuring and improve quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your dental information for treatment, payment, and health care operations, we may use and disclose dental information for the following purposes:

NOTIFICATION: We may use and disclose dental information to notify or help notify: a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, dental supplies, x-ray or other dental information for you.

RESEARCH IN LIMITED CIRCUMSTANCES: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of dental information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the dental information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

SPECIALIZED GOVERNMENT FUNCTIONS: Subject to certain requirements, we may disclose or use dental information for military

INFORMED CONSENT

1. **Examinations and X-rays:** I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan.

(initials_____)

2. **Drugs, Medications, And Sedation:** I have been informed and understand that antibiotics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction) They may cause drowsiness and lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medication and drugs that may have been given me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

(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, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

(initials_____)

4. **Temporomandibular Joint Dysfunction (TMD):** I understand that symptoms of 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 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, and the cost of which is my responsibility.

(initials_____)

5. **Fillings:** I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of newly placed filling.

(initials_____)

6. **Removal Of Teeth:** Alternatives to removal have been explained to me (root canal therapy, crowns and peridontal surgery, ect.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and may be necessary to have further treatment. I understand the risk 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 (Parasthesia) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsiblity.

(initials_____)

7. **Crowns, Bridges, Caps, Veneers and Bonding:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be 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 that the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation. It has been explained to me that , in a very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may effect tooth surfaces and may require modification of daily cleaning procedures.

(initials_____)

8. **Dentures Complete Or Partial:** I realize that full or partial dentures are artificial, constructed of plastic, metal, and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (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 included in the initial denture fee.

(initials_____)

9. **Endodontic Treatment (Root Canal):** I realize there is no guarantee that root canal treatment will save may 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 (apicoetomy.)

(initials_____)

10. **Periodontal Treatment (Scaling and Root Planing) / Prophylaxis:** I understand that I have a serious condition causing gum inflammation and or bone loss, and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery, and or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations.

(initials_____)

I understand that dentistry is not an exact science and that therefore reputable Practitioners cannot properly 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 understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also 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 nor OC Smile, is responsible for my dental treatment. I acknowledge the receipt of the understand postoperative instruction and have been given an appointment date to return. I have received the Dental Materials Fact Sheet.

_____

Signature of responsible party or patient (Parent if patient is a minor) Date

_____

Doctor Signature Witness

General Media Release Form - OC Smile & OC Dental Center

1) I, the undersigned, hereby authorize **OC Dental Center & OC Smile** to photograph me, take motion pictures of me, take video footage of me, and/or make electronic sound recordings of me (herein referred to as photographic or electronic reproductions).

2) I authorize the use of any such photographic or electronic reproductions of me for any purpose, including, but not limited to educational and other public media as may be deemed appropriate by **OC Dental Center & OC Smile** (I understand that I may be identifiable from such photographic or electronic reproduction).

Agreed and accepted by:

Print Name _____

Signature _____ Date _____

I am signing this form as an individual ☐ Yes ☐ No

I am signing this form as a representative of a family, and have full authority to grant release for this family ☐ Yes ☐ No

PARENTAL CONSENT

I certify that I am the parent or guardian of the individual above, _____, a minor under the age of eighteen years. I hereby agree to assume legal responsibility for his/her authorizations referred to in this General Media Release.

_____ _____

Signature of Applicant's Parent/Guardian Date

(____)_____

Phone Number (if different)