

Welcome



Select Dental & Orthodontics

PATIENT INFORMATION

Has any member of your family been a patient of our office? YES NO

Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: () _____ - _____ Work: () _____ - _____ Cell Phone () _____ - _____

D.O.B: ____/____/____ Age _____ Sex: Male Female S.S# _____ - _____ - _____

E-Mail Address: _____

Employer: _____
(Name of Company) (Address) (Phone)

MARITAL STATUS

☐ Minor ☐ Single ☐ Married

Name of Spouse: _____

Who should we contact in an emergency: _____ Phone: _____

SUBSCRIBER/RESPONSIBLE PERSON

Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: () _____ - _____ Work Phone () _____ - _____

SS#: _____ - _____ - _____ D.O.B: ____/____/____

Employer: _____ Phone: () _____ - _____
(Name Of Company) (Address)

Whom should we thank for referring you to our office: _____

METHOD OF PAYMENT

Full payment for the dental treatment provided is expected at the time of service. For your convenience, we accept cash, checks, and all major credit cards. For our patients who need extended payments, we offer **CARE CREDIT/CITI FINANCIAL**.

A note about keeping your appointments.

We reserve time for you. **There is a charge for broken appointments.** Failure to notify the office less than 48 hours constitutes a broken appointment. (This applies only to weekdays) (Initials)

TRANSFER CANCELLATION PROCEDURE

DOWNTOWN FAMILY DENTAL reserves the right to not treat a patient and ask that the patient transfer to another dentist of their choice when it is determined that the patient's conduct and/or requirements are detrimental to the best interest of the practice.

Arbitration Agreement

Patient's Last Name: _____ Patient's First Name: _____

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

Article 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the provider, including any spouse or heirs of the patient and any children, whether born or unborn at the time of occurrence of any claim. This includes, but is not limited to, any dispute arising from tort, contract negligence or otherwise for monetary damage, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages or actions brought upon on behalf of patient y by third parties, shall be submitted to binding arbitration and not a lawsuit. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this agreement relates to the claims against the provider and any consenting substitute provider, as well as the provider's partners, associates, associations, corporations or partnerships and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to the full and complete settlement of any dispute arbitrated under this agreement.

Article 3: The arbitrator shall have the authority to award any remedy or relief that a court of the state of California could order or grant, but no other remedy or relief. The award must be limited to the relief available to a California state court and under Cal. Law for the cause(s) of action at issue in arbitration. However, each party shall bear its own costs, expenses, legal fees, witness expenses, and 50% of the arbitrator's fees and such expenses may not be awarded against the opposing party. The provisions of California Law applicable to healthcare providers shall apply including, but not limited to, California Code of Civil Procedure sections 667.7 and 425.1 and California Civil Code sections 3333.1 and 3333.2. I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Article 4: I have read and understood this agreement. I understand that in the case of a pregnant woman, the term "patient" as used herein means both the mother and mother's expected child or children.

Article 5: I understand that I do not have to sign this agreement to receive services, and that if I do sign this agreement and change my mind within 30 days as of today, then I may cancel this agreement by giving written notice to the undersigned provider within 30 days of the date of my signature below stating that I want to withdraw from this Arbitration Agreement.

By Initialing below, patient intends and acknowledges this Arbitration Agreement to cover claims arising before the date it is signed. This Arbitration Agreement is effective as of the date of this provision of the first care or service of any kind. Patient acknowledges to have received a signed copy of this agreement.

Initials or Patient or Patient's Legal Representative

If any provisions 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.

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

Patient, Parent, Guardian or Legally Authorized Representative of Patient

Date

Providers Agreement to Arbitrate: In consideration of the foregoing execution of this Patient-Provider Arbitration Agreement, I likewise agree to be bound by the terms set forth in this agreement and in the rules specified in Article 3 above.

Select Dental & Orthodontics

Date



Select Dental & Orthodontics

2171 Torrance Blvd.

Torrance, CA 90501

(310) 320-0707 Fax (310) 618-1457

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, , have received a copy of this office's **Notice of Privacy Practices**.

(Please Print Name)

(Signature)

(Date)

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIAL FACT SHEET (DMFS)

I, , acknowledge I have received a copy of the Dental Material Fact Sheet from **Select Dental & Orthodontics**.

(Please Print Name)

(Signature)

(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)



Select Dental & Orthodontics

Patient Testimonial/Photo Release

This is an agreement between Select Dental & Orthodontics and all of its practitioners and Patient :

I, [REDACTED] (Patient), grant Select Dental & Orthodontics and its affiliated dentists and dental professionals, all rights to the images, video and audio captured during my dental visit. There is no compensation for the use of these images. Select Dental & Orthodontics and it's dentists retain the right to use all images for: communicating with the laboratories for purpose of fabrication of restorations, collaborating with other dentist, and working with dental students and residents for academic intend, use on our website, social media and other online marketing initiatives.

Patient Name: [REDACTED]

Patient Signature: [REDACTED]

Date: [REDACTED] / [REDACTED] / [REDACTED]

Signature of a Staff Member: _____