



Patient Information Sheet

Chart # _____ Office Location _____ Date _____

Patient Information

First Name: _____ Middle Int. _____ Last Name: _____ Date of Birth: ____/____/____
 Mother's Maiden Name: _____ Do you: Rent Own Do you have a Credit/ Debit Card: Yes No
 Home Address: _____ Apt # _____ City: _____ State: _____ Zip: _____
 Home Phone #: () _____ Cell Phone #: () _____ Sex: (M) (F)
 E-Mail address: _____ DL/ ID # _____ State: _____ Social Security #: _____ - _____ - _____
 Employer: _____ Position: _____ How Long: _____
 Employer Address: _____ Work Phone Number: () _____ Ext.: _____
 City: _____ State: _____ Zip: _____
 In Case of Emergency, contact: (Name) _____ Phone #: () _____ Cell Phone #: () _____
 Relationship: _____

How do you intend to pay? Cash Credit Insurance Medi-Cal Other _____

Responsible Party

Relationship to Patient: _____

(Disregard if same as above)

First Name: _____ Middle Int. _____ Last Name: _____ Date of Birth: ____/____/____
 Mother's Maiden Name: _____ Do you: Rent Own Do you have a Credit/ Debit Card: Yes No
 Home Address: _____ Apt # _____ City: _____ State: _____ Zip: _____
 Home Phone #: () _____ Cell Phone #: () _____ Sex: (M) (F)
 E-Mail address: _____ DL/ ID # _____ State: _____ Social Security #: _____ - _____ - _____
 Employer: _____ Position: _____ How Long: _____
 Employer Address: _____ Work Phone Number: () _____ Ext.: _____
 City: _____ State: _____ Zip: _____

How do you intend to pay? Cash Credit Insurance Medi-Cal Other _____

Personal References

First Name: _____ Last Name: _____ Relationship: _____
 Home Phone Number: () _____ Home Address: _____ Apt # _____
 City: _____ State: _____ Zip: _____
 First Name: _____ Last Name: _____ Relationship: _____
 Home Phone Number: () _____ Home Address: _____ Apt # _____
 City: _____ State: _____ Zip: _____

Primary Insurance Information

Insured First Name: _____ Last Name: _____ Date of Birth: ____/____/____
 Insured Address: _____
 Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's Social Security Number: _____ - _____ - _____
 Employer _____ Employer's Phone Number () _____ Insurance Company: _____
 Insurance Co. Address: _____ Effective Date _____
 Group #: _____ Policy #: _____ Phone Number of Insurance Co.: () _____
 Name of Union and Local Union Number _____

Secondary Insurance Information

Insured First Name: _____ Last Name: _____ Date of Birth: ____/____/____
 Insured Address: _____
 Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's Social Security Number: _____ - _____ - _____
 Employer _____ Employer's Phone Number () _____ Insurance Company: _____
 Insurance Co. Address: _____ Effective Date _____
 Group #: _____ Policy #: _____ Phone Number of Insurance Co.: () _____
 Name of Union and Local Union Number _____

I request that all dental benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the provider of service. I understand that I am financially responsible for all charges for services performed by provider. If insurance proceeds are insufficient to cover my obligations for services rendered, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.
I am aware that by signing below I certify that all information is complete and correct. Western Dental Services, Inc., may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by law. This is my authorization for Western Dental Services, Inc., to verify credit history.

Signature of Patient

Signature of Responsible Party

For Office Use Only

VRU Code: _____ Date: _____ VRU Code: _____ Date: _____
 Signature of Employee: _____ Form 40A Rev. 8 (11/08)

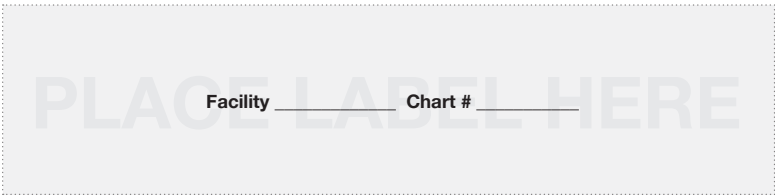
HEALTH HISTORY

DATE ____-____-____ PATIENT NAME _____

AGE _____ SEX M / F HEIGHT _____ WEIGHT LBS. _____

In case of an emergency, contact (person) _____

Phone # () _____ - _____



INSTRUCTIONS:

Answer all questions and fill in the blank spaces when indicated. Answers to the following questions are for our records only and will be kept confidential.

| | |
|---|--|
| Why are you here today? _____ | When were your last dental x-rays taken? ____/____/____ |
| When was your last visit to a dental office? ____/____/____ | Are those x-rays available? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| PRIOR DENTIST'S NAME and PHONE NUMBER: _____ (____) _____ | |

| | |
|---|--|
| 1. Are you in poor health? <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth, head or neck? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you had any serious illness, an operation, or hospitalization in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what was the problem? _____ | 8. Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Do you have or are you being treated for tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you have allergies, hives or a skin rash? <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Do any of your teeth hurt? Which ones? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Are you allergic to latex or rubber products? <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Do you wear a partial denture or any other removable dental appliance? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Do you have any blood disorder such as anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | |
|---|--|
| 1. Has there been any change in your general health within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Have you taken the diet medication Redux® (Fen-Phen)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are you currently under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No A. If so, what is the condition being treated _____ | 8. Are you taking any medications <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate which. Antibiotics or sulfa drugs <input type="checkbox"/> Anticoagulants (blood thinners) <input type="checkbox"/> Medicine for high blood pressure <input type="checkbox"/> Cortisone (steroids) <input type="checkbox"/> Antidepressants <input type="checkbox"/> Sedatives <input type="checkbox"/> Antihistamines <input type="checkbox"/> Aspirin <input type="checkbox"/> Insulin, tolbutamide (orinase) or similar drug <input type="checkbox"/> Digitalis or drugs for heart trouble <input type="checkbox"/> Nitroglycerin <input type="checkbox"/> Oral contraceptives or other hormonal therapy <input type="checkbox"/> Medications to treat osteoporosis such as Fosamax, Aredia, Boniva, Zometa (Bisphosphonates) <input type="checkbox"/> Herbal remedies <input type="checkbox"/> Any other drug or medicine _____ |
| 3. The name and address of my physician is _____ _____ | 9. Are you allergic or have you reacted adversely to any of the following: Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No Barbiturates, sedatives or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No Nickel or other metals <input type="checkbox"/> Yes <input type="checkbox"/> No Other allergies <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you have or have you had any of the following diseases or problems: A. Damaged heart valves or artificial heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No B. Congenital heart lesions or murmurs <input type="checkbox"/> Yes <input type="checkbox"/> No C. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, or other) <input type="checkbox"/> Yes <input type="checkbox"/> No 1) Do you have pain in your chest upon exertion? <input type="checkbox"/> Yes <input type="checkbox"/> No 2) Are you ever short of breath after mild exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No 3) Do your ankles swell? <input type="checkbox"/> Yes <input type="checkbox"/> No 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No 5) Do you have a cardiac pacemaker? <input type="checkbox"/> Yes <input type="checkbox"/> No D. Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No E. Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No F. Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No G. Emphysema or respiratory problems <input type="checkbox"/> Yes <input type="checkbox"/> No H. Persistent cough or cough up blood <input type="checkbox"/> Yes <input type="checkbox"/> No I. Fainting spells or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No J. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No 1) Do you urinate (pass water) more than 6 times a day? <input type="checkbox"/> Yes <input type="checkbox"/> No 2) Are you thirsty much of the time? <input type="checkbox"/> Yes <input type="checkbox"/> No 3) Does your mouth frequently become dry? <input type="checkbox"/> Yes <input type="checkbox"/> No K. Kidney trouble <input type="checkbox"/> Yes <input type="checkbox"/> No L. Stomach troubles/ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No M. Hepatitis, jaundice or liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No N. Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No O. HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No P. Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No Q. Arthritis or painful, swollen joints <input type="checkbox"/> Yes <input type="checkbox"/> No R. Do you have a prosthetic hip <input type="checkbox"/> joint prosthesis <input type="checkbox"/> implants <input type="checkbox"/> bone plates <input type="checkbox"/> or screws <input type="checkbox"/> other _____ | 10. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Do you have any problems associated with your menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No 12. Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No 13. Do you have any disease, condition, or problem not listed above that you think I should know about? <input type="checkbox"/> Yes <input type="checkbox"/> No |

DENTAL HISTORY :

| |
|---|
| 14. Is there anything about your teeth or smile that you would like to change? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, explain _____ |
| 15. Have you had any serious trouble associated with any previous dental treatment? If so, explain _____ <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. How often do you brush your teeth? _____ When? _____ |
| 17. How often do you floss? _____ When? _____ |
| 18. Do your gums bleed or hurt? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Are any of your teeth sensitive to: Hot <input type="checkbox"/> Cold <input type="checkbox"/> Sweets <input type="checkbox"/> Pressure <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Does food get caught in your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Do you have frequent headaches <input type="checkbox"/> neck aches <input type="checkbox"/> or shoulder aches? <input type="checkbox"/> <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Have you experienced any pain or soreness in the muscles of your face or around your ear? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Does your jaw click or pop? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Do you wear any type of denture or partial denture? <input type="checkbox"/> Yes <input type="checkbox"/> No A. Date of placement ____ / ____ / ____ B. Is there anything about the denture that you would like to change? <input type="checkbox"/> Yes <input type="checkbox"/> No |

FOLLOW UP to Medical History by DENTIST ONLY _____

I hereby certify that I have read the foregoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays and examination.

SIGNATURE OF PATIENT or Guardian if patient is a minor _____ DATE ____-____-____

SIGNATURE OF DENTIST _____ DATE ____-____-____

| UPDATE | DATE | COMMENTS | DR. SIGNATURE | EMPLOYEE# | PATIENT SIGNATURE |
|--------|------|----------|---------------|-----------|-------------------|
| | | | | | |



HOW DID YOU HEAR OF US ?

• PLEASE CHECK ONE BOX ONLY !

NAME _____

ZIP CODE _____

OFFICE _____

DATE _____

- A. SPANISH T.V.
- B. ENGLISH T.V.
- C. SPANISH RADIO
- D. ENGLISH RADIO
- E. FLYER / MAILER / COUPON
- F. NEWSPAPER / MAGAZINE
- G. SPANISH YELLOW PAGES
- H. ENGLISH YELLOW PAGES
- I. BILLBOARD / BUS SIGN
- J. BUILDING LOCATION SIGN

- K. FRIEND / NEIGHBOR / RELATIVE
- L. TELEPHONE / LETTER / RECALL
- M. DENTAL PLAN REFERRAL
- N. MANAGED CARE - (GMC, ETC.)
- O. W.D. VAN 1-800-844-4444
- P. W.D. BOOTH (SWAPMEET, SPECIAL EVENT, ETC.)
- Q. INTERNET
- R. **W.D. DENTIST**
- S. **W.D. ORTHODONTIST**

Form 232 (Rev. 11/08)



¿CÓMO ENCONTRÓ INFORMACIÓN SOBRE NUESTRO CONSULTORIO?

¡POR FAVOR, MARQUE UN CUADRO SOLAMENTE!

NOMBRE _____

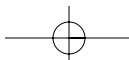
ZONA _____

OFICINA _____

FECHA _____

- A. TELEVISIÓN EN ESPAÑOL
- B. TELEVISIÓN EN INGLÉS
- C. RADIO EN ESPAÑOL
- D. RADIO EN INGLÉS
- E. VOLANTES/AVISOS POR CORREO/CUPONES
- F. PERIÓDICO/REVISTA
- G. GUÍA TELEFÓNICA EN ESPAÑOL
- H. GUÍA TELEFÓNICA EN INGLÉS
- I. CARTELERA/ANUNCIO EN EL AUTOBÚS
- J. CARTEL EN UN EDIFICIO

- K. AMIGOS/VECINOS/PARIENTES
- L. TELÉFONO/CARTA/RECORDATORIO
- M. REFERENCIA POR PARTE DE UN PLAN DENTAL
- N. ATENCIÓN COORDINADA (GMC, ETC.)
- O. CAMIONETA DE WESTERN DENTAL 1-800-844-4444
- P. QUIOSCO DE WESTERN DENTAL (FERIAS AL ESTILO "SWAPMEET", ALGÚN EVENTO ESPECIAL, ETC.)
- Q. INTERNET
- R. **UN DENTISTA DE WESTERN DENTAL**
- S. **UN ORTODONCISTA DE WESTERN DENTAL**





ARBITRATION AGREEMENT

Patient Chart No. _____

Patient Name: _____

Office Location: _____

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any 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: All Claims Must Be Arbitrated: It is the intention and agreement of the parties that this arbitration agreement shall cover all claims or controversies relating to the matters described in Article 1 above, except claims within the jurisdiction of the Small Claims Court, whether in tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described in Article 1 may arise out of or in any way relate to treatment or services provided or not provided by Western Dental Services, Inc. ("Western") or any employee or agent or providers of Western, including any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. The undersigned understands and agrees that if the undersigned signs this Contract on behalf of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person.

The reference to Western includes the corporation, and its employees, agents and providers. Filing any action in any court by Western to collect any fee from Patient shall not waive the right to compel arbitration of any claim described in Article 1. However, following the assertion of any claim against Western, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by the same arbitration.

Article 3: Procedures and Applicable Law: Patient shall initiate arbitration by serving a Demand for Arbitration on Western and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: General Counsel, Western Dental, 530 S. Main Street, Suite 600, Orange, CA 92868. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient and his/her attorney. Patient and Western agree that any arbitration hereunder shall be conducted by a single, neutral arbitrator selected by the parties and shall be resolved using the rules of the American Arbitration Association. (Arbitration, however, shall not be conducted by the American Arbitration Association.) Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Civil Code §§ 3333.1 and 3333.2, Code of Civil Procedure §§ 340.5, 667.7, 1281-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1- 9), as in effect from time to time.

Article 4: Retroactive Effect: Patient intends this Contract to cover services rendered by Western not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Severability: 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 Contract. 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 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.

_____, 20_____
Print Patient's Name (Signature of Patient, Parent, Guardian or Legally Authorized Representative of Patient)

WESTERN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing agreements under this Contract, Western likewise agrees to be bound by the terms set forth in this Contract and to the rules specified in Article 3 above.

Prepared By Western Employee Print Name Date Signed

A signed copy of this document is to be given to Patient. The Original is to be filed in Patient's dental chart.



Dear Patient,

In keeping with the standards of the profession and the recent developments in sterilization and infection control, we at Western Dental have formulated this general public information bulletin to give our patients an idea of how seriously we take the safety and well being of our patients.

- 1) All doctors, hygienists and assistants wear gloves, masks, and face shields or goggles.
- 2) Doctors and assistants wash their hands and change gloves with every patient.
- 3) Dental drill handpieces are cleaned, bagged and sterilized prior to use on each patient.
- 4) All instruments are scrubbed, cleaned, bagged and sterilized according to guidelines set forth by the Center for Disease Control & Prevention.
- 5) All instruments are sterilized in autoclaves or chemical vapor sterilizers according to recommended procedures. If the instruments are heat sensitive, an overnight (10 + hours) sterilized soak is done.
- 6) Western Dental test all sterilizers weekly and this is confirmed through independent lab analysis.
- 7) All operating surfaces are cleaned with EPA registered hospital grade surface disinfectants.
- 8) Many disposable items are used. Once used, they are discarded. Some examples are the injection needles, plastic suction tips and the polishing cups.
- 9) An independent company has been retained to vaccinate and test our staff for the Hepatitis B virus.
- 10) Our staff, while taking x-rays, always use fresh gloves and each x-ray holder is individually bagged and sterilized.
- 11) Infection control seminars are held for all our dental offices throughout the year.
- 12) Our company has retained an infection control consultant who randomly inspects our offices on a routine basis. Many of these inspections are done on a "surprise" basis to ensure that the offices are following accepted guidelines. In addition to these inspections, our own administrative staff performs regularly scheduled audits on all our offices.

Western Dental provides dental care services without discrimination based on race, religion, color, national origin, sex, sexual orientation, physical or mental disability, age or marital status and protects the privacy of each of its patients. If any questions or concerns arise regarding the dental care, treatment or services you have received, contact Western Dental Services Inc. at 1-800-992-3366 or write the Western Dental Services, Inc., P.O. Box 14227, Orange, California, 92863.