3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

By providing your e-mail address you greatly help our practice to stay "GREEN" and agree to receive (check all that apply)

☐ Appointment Reminders ☐ Practice Newsletter

☐ Correspondence from your doctor

What is your preferred method of contact?

☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ E-Mail

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat

☐ Morning ☐ Afternoon ☐ Evening ☐ Any time

3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Whom may we thank for referring you to our practice?

- ☐ Dental Office
- ☐ Yellow Pages
- ☐ Internet
- ☐ Newspaper
- ☐ School
- ☐ Work
- ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Primary Medical Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Secondary Medical Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: cash, all major credit cards, Personal checks, web based payments (e.g. PayPal), third-party financing * Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

Our practice may/or may NOT be a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $25 ($50 for broken/failed appointments without notice) or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $25 or deposit to reserve the appointment time again, may be required.

Consent for Dental Radiographs and Examination. For an initial complete dental examination and evaluation, I authorize the doctor and his/her auxiliaries to take any dental X-rays they feel necessary. I understand that the doctor may not be able to perform any treatment without these X-rays. After the initial examination and diagnosis, the doctor will inform me of his/her recommendation for treatment, as well as any options for such treatment. I understand that this initial visit does not include a prophylaxis (cleaning). However, the doctor or hygienist may provide this service, if time permits. Initials

3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. (initial)

I have read the above and agree to the financial and scheduling terms. (initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) (initial)

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. (initial)

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. (initial)

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date:

Relationship to Patient:

Response Date:

3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

My preferred email address for communications with Infinite Dental Wellness is:

* _____

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____

3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Dental Health History Form

Today's Date

Patient Name:* * Last First MI Preferred Name

What are your goals in coming to our practice today?

*

What is important to you in a dentist or dental practice?

*

What has been your experience with the dentist in the past?

*

Date of last dental radiographs (x-rays) and exam

Date of last hygiene continuing care appointment (cleaning or periodontal maintenance)

Former Dentist

Have you had problems with prior dental treatment?

Are you experiencing any pain now?

* ◯ Yes ◯ No

If yes, please describe

3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Have you been anxious about having dental treatment?

* ◯ Yes ◯ No

If yes, would you be comfortable sharing why?

Would you like to discuss this concern with the doctor to learn about your relaxation options?

What concerns do you currently have with your oral health or smile? (check all that apply)

- ☐ Jaw joint pain
- ☐ Discolored teeth
- ☐ Missing teeth
- ☐ Loose tooth/teeth
- ☐ Unhappy with appearance of teeth
- ☐ Underbite
- ☐ Old fillings (gold or silver/amalgam)
- ☐ Speech problems
- ☐ Tooth sensitivity to hot/cold or anything else
- ☐ Difficulty chewing
- ☐ Other
- ☐ Clenching or grinding of teeth
- ☐ Crowding/Crooked teeth
- ☐ Spaces in between teeth
- ☐ Tooth shape or size
- ☐ Overbite
- ☐ Uncomfortable bite
- ☐ Old crowns
- ☐ Too much gum tissue when I smile
- ☐ Food gets caught in between teeth
- ☐ Bad breath

Have you ever had orthodontic treatment?

* ◯ Yes ◯ No

Have you ever had periodontal (gum tissue) treatment, such as deep cleaning, root planing, or periodontal surgery?

* ◯ Yes ◯ No

3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Have you whitened your teeth in the past?

* ◯ Yes ◯ No

If yes, what method?

Are you interested in learning more about the following? (check all that apply)

- ☐ Teeth whitening
- ☐ Veneers
- ☐ Dental Implants
- ☐ At-home oral hygiene care
- ☐ Oral hygiene care for infants and toddlers
- ☐ Orthodontic treatment
- ☐ Tooth colored fillings
- ☐ How to prevent periodontal (gum) disease
- ☐ Periodontal (gum) treatment during pregnancy

Response Date:

Medical/Health History

Please complete the following

Today's Date

Patient Name:* Last * First MI Preferred Name

Phone: * Home Work Ext Mobile Best time to call:

I. Circle appropriate answer

Is your general health good?

* Yes No

If No, please explain

Has there been a change in your health within the last year?

* Yes No

If yes, please explain

Are you being treated by a physician now?

* Yes No

If yes, please explain

Date of last medical exam?

II. Please check any health conditions that apply:

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Acid Reflux/GURT
☐ AIDS/HIV	☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro
☐ Allergy - Hay Fever	☐ Allergy - Latex	☐ Allergy - metal	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Allergy - Valium	☐ Allergy-Epinephrine	☐ Allergy-Local Anesth
☐ Allergy-Tetracycline	☐ Anemia/Blood Disease	☐ Anxiety/Depression	☐ Arthritis/Rheumatism
☐ Artificial Joints	☐ Asthma	☐ Chemotherapy	☐ Chest Pain/Angina
☐ Diabetes	☐ Difficulty Swallowng	☐ Dizziness/Fainting	☐ Dry mouth
☐ Emotional Disorder	☐ Epilepsy/Seizures	☐ Excessive Bleeding	☐ Excessive thirst
☐ Fosamax/Bisphosphnts	☐ Frequent urination	☐ Glaucoma/Eye Disease	☐ Head Injuries
☐ Headaches/Migrens	☐ Heart attack	☐ Heart Disease	☐ Heart Murmur
☐ Hepatitis	☐ Herpes/Cold Sores	☐ High Blood Pressure	☐ Hospitalization/Surg
☐ HPV	☐ Kidney/Bladr Disease	☐ Liver Dis./Jaundice	☐ Osteoporosis
☐ Pacemaker	☐ Persistent cough	☐ Pregnant/Nursing	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Sinus Problems	☐ Skin Disease
☐ Stomach Problm/Ulcer	☐ Stroke	☐ Thyroid Disease	☐ TMJ Disease/Poping
☐ Transplants	☐ Tuberculosis	☐ Tumors/Cancer	☐ Venereal Disease/STD

III. Are you taking or have you taken any of the following?

Please check all that apply

- ☐ Recreational drugs
- ☐ Corticosteroids
- ☐ Alcohol
- ☐ Antibiotic
- ☐ Aspirin
- ☐ Oral Contraceptives
- ☐ Over the counter medicines
- ☐ Tobacco in any form
- ☐ Bisphosphonate (e.g. Fosamax)
- ☐ Dietary or Other Supplements
- ☐ Weight loss medications

IV. All patients

Do you have or have you had any other diseases or medical problems NOT listed on this form?

* ◯ Yes ◯ No

If yes, please explain

Have you been pre-medicated for dental treatment?

* ◯ Yes ◯ No

If yes, why?

Have you ever taken Fen-Phen?

* ◯ Yes ◯ No

If yes, when?

Is there any issue or condition that you would like to discuss with the doctor in private?

* ◯ Yes ◯ No

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

Signature: _____ Date: _____

Physician's Name

_____

Physician's Phone Number

_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient (Guardian, if underage)

Signature: _____ Date:* _____

Doctor

Signature: _____ Date: _____

Response Date: _____

3600 No. Verdugo Rd. Suite 201
Glendale CA 91208

(818)541-1110
Info@InfiniteDentalWellness.com

Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of guarantor of payment/responsible party:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____