BLOOMFIELD DENTAL CENTER
IHHAB GUERGUIS, D.D.S
12657 166th street, Cerritos. CA 90703
5629266502

Name _____ **Chart#** _____

Patient
Name _____
Last first
Address _____ Apt.# _____
City _____ zip code _____
How long at this address? _____
Phone #( ) _____Cell#( )_____
Email Add. _____
Social security # _____
Age _____ Birth Date _____

Responsible party (if same as above, pls skip)
Name _____
Last first
Address _____ Apt.# _____
City _____ zip code _____
How long at this address? _____
Phone #( ) _____Cell#( )_____
Social security # _____
Relationship to patient _____
Age _____ Birth Date _____

Employment
Occupation _____
Employer _____
How Long? _____
Business Address _____
City _____ zip code _____
Business Phone # ( ) _____ EXT. # _____

Credit Information
Own _____ Rent _____ How long? _____
(If less than 1 year) _____
Previous Address _____
How long? _____
Credit Card Name _____
Bank _____
Car owned: Yes _____ No _____ Type _____
Monthly Income _____
Driver's License _____

Reference
Name _____
Last first
Address _____ Apt.# _____
City _____ zip code _____
Phone #( ) _____Cell#( )_____

Name _____
Last first
Address _____ Apt.# _____
City _____ zip code _____
Phone #( ) _____Cell#( )_____
Spouse Name _____
Last first
Work # ( ) _____
Work # ( ) _____

Insurance
Primary Insurance Company (PPO)
Name _____
Address _____ zip code _____
City _____
Ins. Co. Phone# _____
Employer _____
Union/Local _____Group# _____
Insured's Name _____
Insured's Soc. Sec# _____
Birth Date _____
Secondary Insurance Company (PPO)
Name _____
Address _____ zip code _____
City _____
Ins. Co. Phone# _____
Employer _____
Union/Local _____Group# _____
Insured's Name _____
Insured's Soc. Sec# _____
Birth Date _____
Managed Care Plan (HMO)
Plan Name _____ Group # _____
Plan # _____ Employer _____
Insured's Name _____
Insured's Soc. Sec# _____

Getting To Know You
Are there other members of your family who are not patients at our office?
Yes _____ No _____
Pls. list names & relationship (son, daughter, husband) below
1: _____ 2: _____
3: _____ 4: _____
How did you hear about us ? ☐Family/ Friend ☐Letter/Ad
☐Tv/Internet ☐ Sign/Drove by ☐ Insurance
☐Other _____
I'd like inf. In Spanish: Yes _____ No _____

Person to contact for Emergency:
Name _____
Last first
Address _____ Apt.# _____
City _____ zip code _____
Phone #( ) _____Cell#( )_____
Physician name _____ TEL # _____
ID# _____ Pharmacy Phone# _____

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 my additional applicants, including requiring reports from credit reporting agencies.
3. I hereby authorize payment directly to dr. Guerguis' office of the group insurance benefits otherwise payment to me. I understand that I am financially responsible for any charges not covered by this authorization.

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

PATIENT INFORMATION

IHAAB GUERGUIS, D.D.S 12657 166st street, Cerritos. CA 90703

Date_____ M_____ F_____ Chart #_____Name_____ Birth Date:_____
Last first

Dental History

1.Why are you here today? Check-up_____ Cleaning_____ other_____
Toothache_____ Chief Complaint _____

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

4. When did you last visit a dentist? _____ 5. Did you have a cleaning? _____

6. When were dental X-Rays taken? _____

7. Have you ever had prolonged bleeding after an extraction? Yes ____ No ____ if yes, please specify _____

8. Have you had problems with past dental treatment? Yes ____ No ____ if yes, please specify _____

9. Do you have symptoms near your ears associated with movement of your jaw such as clicking, popping, pain or locking open? _____
Yes ____ No _____ if yes, please specify _____

10. Have you ever been diagnosed or treated for TMJ (1.Symptoms 2. or Clenching 3. or Grinding?)
Yes ____ No _____ if yes, please specify _____

11. Do your gums bleed easily? Yes ____ No ____ 12. Do you feel you have bad breath? Yes ____ No ____

13. Are your teeth sensitive to hot or cold? Yes ____ No ____ 14. Would you like your teeth whiter? Yes ____ No ____

15. Are there any cosmetic changes you would like to have done on your teeth? Yes ____ No ____
if yes, please specify _____

16. Are there other conditions of which we should be aware? 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, locale anesthetics, tranquil izers or any other drugs or medicine?
3. Are you allergic to latex or any rubber products? Yes
4. Are you taking any medication at this time, including birth control? Yes No If yes, please specify

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5. **Have you used** Bisphosphonate **in the past**? Yes_____ No _____
6. (Woman) are you pregnant/Nursing at this time? Yes _____No _____ If yes, please specify how many months _____
7. Are there any other health problems of which we should be advised? Please specify
8. Do you have or have you had, any of the following?

Please check "yes" Or "No"			Doctor Comments	Please check "yes" Or "No"			Doctor Comments
Alcoholism	Yes ☐	No ☐	_____	Heart Murmur	Yes ☐	No ☐	_____
Artificial heart valve	Yes ☐	No ☐	_____	Hear Problems	Yes ☐	No ☐	_____
Aids/ HIV+	Yes ☐	No ☐	_____	Hepatitis	Yes ☐	No ☐	_____
Anemia	Yes ☐	No ☐	_____	High BL. Presure	Yes ☐	No ☐	_____
Angina	Yes ☐	No ☐	_____	Implants/Surgical Screws	Yes ☐	No ☐	_____
Arthritis	Yes ☐	No ☐	_____	Jaundice	Yes ☐	No ☐	_____
Asthma	Yes ☐	No ☐	_____	Joint Prosthesis	Yes ☐	No ☐	_____
Bleeding Problems	Yes ☐	No ☐	_____	Kidney Disease	Yes ☐	No ☐	_____
Cancer	Yes ☐	No ☐	_____	Liver Problems	Yes ☐	No ☐	_____
Chemo/Red Therapy	Yes ☐	No ☐	_____	Low BL. Pressure	Yes ☐	No ☐	_____
Cholesterol	Yes ☐	No ☐	_____	Lung Disease	Yes ☐	No ☐	_____
Cosmetic Surgery	Yes ☐	No ☐	_____	Pacemaker	Yes ☐	No ☐	_____
Dizzy Spells	Yes ☐	No ☐	_____	Recreational Drugs	Yes ☐	No ☐	_____
Drug	Yes ☐	No ☐	_____	Rheumatic Fever	Yes ☐	No ☐	_____
Emphysema	Yes ☐	No ☐	_____	Sexually Trans. Disease	Yes ☐	No ☐	_____
Epilepsy	Yes ☐	No ☐	_____	Sinus trouble	Yes ☐	No ☐	_____
Fainting	Yes ☐	No ☐	_____	Smoking	Yes ☐	No ☐	_____
Glaucoma	Yes ☐	No ☐	_____	Stroke	Yes ☐	No ☐	_____
Heart Attack	Yes ☐	No ☐	_____	Thyroid Problems	Yes ☐	No ☐	_____
Heart Surgery	Yes ☐	No ☐	_____	Tuberculosis	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 the x-ray & oral examination.

Patient's Signature (or parent if patient is a minor) _____ Date _____ Doctor Signature _____

1. **Patient's Signature _____ Doctor's Signature _____ Date _____**
2. **Patient's Signature _____ Doctor's Signature _____ Date _____**
3. **Patient's Signature _____ Doctor's Signature _____ Date _____**
4. **Patient's Signature _____ Doctor's Signature _____ Date _____**
5. **Patient's Signature _____ Doctor's Signature _____ Date _____**
6. **Patient's Signature _____ Doctor's Signature _____ Date _____**
7. **Patient's Signature _____ Doctor's Signature _____ Date _____**

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12657 166st street, Cerritos. CA 90703
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Name _____ Chart _____

1. Work To Be Done

I understand that I am having the following work done: Fillings___, Bridges___, Crowns___, Extraction___, Impacted Teeth Removed___, Sedation___, Root Canals___, Periodontal___, Full Mouth X-Rays___, Other___

2. Drugs, Medications and Sedation. (Initials_____)

I have been informed & understand that antibiotics, analgesics & other medications can cause allergic reaction causing redness & swelling of tissues, pain, itching, vomiting, &/or anaphylactic shock (severe allergic reaction) & they can cause pain, Thrombophlebitis (inflammation of a vein) from intravenous & intramuscular injections, injury to & stiffing of neck & facial muscles, jaw pain, trismus, temporary or permanent nerve damage including a loss of sensation, tingling burning or itching in the tongue, lips, gums, chin & jaw, miscarriage & cardiac arrest. They may cause drowsiness & lack of awareness & coordination which can be increased by the use alcohol or other drugs. I understand & 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 & drugs that may have been given to me on 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 & pain & potential resistance to effective treatment of my condition. (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 were no 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 & additions as necessary.

4. Removal Of Teeth (Initials_____)

Alternatives to removal have been explained to me (root canal therapy, crowns & periodontal surgery, etc.) & I authorize the Dentist to remove the following teeth_____& any others necessary for reasons in paragraph#3. I understand removing teeth does not always remove the infection, if present, & 1t may be necessary to have further treatment. I understand the Risks involved in having teeth removed, are pain, swelling, an increase &/or spread of infection into surrounding tissue & bone, dry Socket, bleeding, scarring, temporary or permanent loss of feeling, itching, tingling or burning in my lips, tongue, cheek, chine, teeth and surrounding tissue that can last for an indefinite period of time, paresthesia , loos of taste, speech difficulty, damage to surrounding or adjacent teeth, bond & dental restoration such as fillings & crowns, injury to soft tissue, opening into one or more sinus cavities, residual tooth or bone spicules which may in the dentist's discretion, be left when complete removal would require extensive surgery or unjustified surgical risks, limitation or pain in the jaw and/or temporomandibular joint-TMJ, fibromyalgia or fractured jaw. I understand I may need further treatment by specialist or even hospitalization if complications arise during of following treatment, the cost of which is my responsibility. (Initials_____)

5. Crowns, Bridges, Caps, Veneers, 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 crown, which may come off easily & 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 cosmetic procedures may result in need for future root canal treatment which cannot always be predicted or anticipated. I understand the cosmetic procedures may affect tooth surfaces and may require modification of my personal cleaning procedures. I am aware that the risks of crowns, bridges & caps include damage o adjacent or opposing teeth, excessive wear on other teeth, accumulation. of plaque in & around the restoration, tooth sensitivity, pain in the teeth, jaw pain and headaches.

6. Dentures – complete or Partial (Initials_____)

I realize that full or partial dentures are artificial appliances, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including to me loosens, soreness & possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement & color) will be the 'teeth in wax' try-in visit. I understand that most dentures require relining approximately three to twelve months after placement. The cost for this procedure is not included in the initial denture fee. I understand that I may need to modify my daily personal cleaning and the risks of dentures include pain, headaches, jaw discomfort & pain, limited opening of the jaw, reduction in supporting bone structure, gum pain, creation of a need for bone removal, recontouring or implants. I understand I may never have unresolved pain or complete satisfaction from my dentures.

7. Endodontics Treatment (Root Canal Therapy) (Initials_____)

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatment, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle, may darken, & must be protected against fracture by placement of a crown (cap) the tooth.

I understand that treatment risks can include, but are not limited to the following:

A. Post treatment discomfort & pain lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.
B. Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.
C. Infection.
D. Restricted jaw opening, painful jaw movement.
E. Breakage of root canal instrument during treatment, which may in the judgment of the doctor be left in the treated root canal or bone as part of the filling material; or it may require surgery for removal.
F. Perforation of the root canal or crown of the tooth with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.
G. Risk of temporary or permanent numbness, burning, tingling or itching in the lips, tongue, chin, gun or cheek.
H. Non-completion of the procedure due to calcified canals, broken instrument or fracture of the root or crown of the tooth.

I. creation of a hole, or perforation by tooth structure or instruments in one more of the sinus cavities which may cause bleeding, sinus infection and a need for further surgical intervention at my expense.
J. Fracture of the tooth.
K. Loss of tooth. (Initials____)

If an "open & medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, & I need to pay for, & finish final root canal therapy. If RCT is not finalized, I expose myself to an increase risk of infection &/or tooth loss.

I understand that root canal therapy is an ameliorative procedure which may not resolve my condition. If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery (Apicoectomy) may be required, or the tooth may have to be extracted. (Initials_____)

8. Fillings

I have been advised of the need for fillings, either silver or composite (bonding), to replace tooth structure lost to decay. I under- stand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post & build-up and crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guide Line and, as such, is a treatment use by Dr. Guerguis's office. The advantages & disadvantages ..of alternate materials have beer explained to me. Risks include continued pain or sensitivity in the tooth, fracture of the tooth, jaw pain and headaches. (Initials_____)

9. Temporomandibular Joint Dysfunction (TMD)

I understand that symptoms of popping, clicking 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, from missing or extracted teeth, or front dental restorations such as fillings, crowns, bridges and dentures. 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 arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility. (Initials_____)

10. Pedodontics (child Dentistry)

I understand that the following procedures are routinely used at Dr. Guerguis's office, as well as being accepted procedures in the dental profession.

A. POSITIVE REINFORCEMENT- Rewarding the child who portrays desirable behavior, by use of compliments, praise, a part or hug, and/or token objects or toys.
B. VOICE CONTROL- The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. PHYSICAL RESTRAINT- Restraining the child's disruptive movements by holding down their hands, upper body, head, and or legs by use of the dentist's or assistant's hand or rum, or by use of a special device (referred to as a 'papoose board'
D. NITROUS OXIDE AND/OR ORAL SEDATION-Nitrous Oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedation are medication administered to children to help them relax. With their use the parent/or guardian must understand that the child should no eat or drink for a period of four hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time.

I understand the need to return to the office within three months following nerve treatment of a 'baby tooth' for evaluation and the possibility of it then needing an extraction.

(Initials___)

ALL PATIENTS:

I understand that dentistry is not an exact science and that therefore reputable practitioners cann0t properly guarantee results nor that the treatment will cure or improve the condition of my teeth and gums. 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 neither Dr. Guerguis's nor any Dentist other that the treating Dentist responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries of Dr. Guerguis's office, to proceed with and perform the dental restorations and treatment as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage i may have, I am responsible for payment of dental fees. I agree to pay any attorney's fee, collections fee or court costs that may be incurred to satisfy any obligation to pay for services rendered.

I hereby authorize the release of any medical information necessary to complete claim reports and I authorize and direct my insurance company to pay all dental benefits allowable in connection with my recent illness to dr. Guerguis's office.

Signature: _____ Date: _____

Doctor: _____ Witness: _____

DENTIST - 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 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 of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the dentist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of occurrence giving rise to any claim. In case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims of monetary damages exceeding the jurisdictional 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 of any 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. However, following the assertion of any claim against the dentist, any fee dispute whether or not subject of any existing court action shall also be resolved by arbitration

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share or 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 fees or witness fees, or other expenses incurred by a party for such party's own benefit.

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

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 the 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 Section 340.5 and 667.7 and Civil Code Sections 333.1 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.

_____

Patient's or patient's Representative's Initials

Article 4: General Provisions: All claims based upon the same, transaction or related Circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred If (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statuette if 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 arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration's.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the dentist within 30 days of signature and if not revoked will govern all dental services received by the patient.

Article 6: Retroactive Effect: if patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first dental services

_____

Patient's or patient's Representative's Initials

If any provisions of this arbitration agreement are held invalid or unenforceable, the remaining provisions shall remain in 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 NEUTRAL ARBITRATION AND ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF TIDS CONTRACT.

By: _____

Dentist or Duly Authorized Representative's Signature **Date**

_____

Print or Stamp Name of Dentist

By: _____

Signature of Translator (if Applicable) **Date**

_____

Print Name of Translator

By: _____

Patient Witness Signature **Date**

_____

Print Patient's Name

By: _____

Patient Witness Signature **Date**

_____

Print Name Relationship to Patient

Please Read & Sign

BLOOMFIELD
DENTAL CENTER

Advanced Beneficiary Notice For Dental treatment

Our office strives to give excellent and thorough care to each patient. We do not adjust our standards or our quality of treatment to the payment policies of health plans. Our recommendations for the treatment are based upon your individual case; however, some health plans do not cover certain procedures.

Our office will bill your insurance. **(HMO Dental Plans do not allow billing of service)**. However, it is possible in your case that your insurance will not reimburse our office for the entire treatment or certain procedures. By signing below, you acknowledge being responsible for payment, should your insurance not reimburse Bloomfield Dental Center in full.

I have been notified of the above and understand some health plans will deny payment for this treatment or procedure. If my health plan does not allow coverage, understand that a statement will be sent it to me, and I will be personally and fully responsible for payment of this service within 30 days.

Thank you for choosing our office to take care of your dental needs.

Signature of patient **Date**

Print name

FINANCIAL POLICY

BLOOMFIELD DENTAL CENTER

IHAAB GUERGUIS D.D.S.
12657 166TH ST.
CERRITOS .CA 90703

In our continued commitment to provide the highest quality dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment. Please check one of the following:

☐ Personal Credit Cards ☐ Visa ☐ Discover ☐ Master Card ☐ American Express	Prepayment We are happy to offer a 5% discount (3% credit card) for services over $1,000.00 when prepaid in full upon scheduling your appointment.

We are pleased to offer two financing options which are administered for us by

☐ Citi Health Card Plan
☐ Care Credit Plan
☐ Dental Fee Plan

Please ask our administrative staff for details and credit applications

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices.	We will, as a courtesy, process your insurance benefits in our office, which will relieve you of this time consuming and sometimes-complicated tasks

I agree that I am fully responsible for the total payment of all procedures performed in this office- this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due and payable at the time services are rendered, regardless of whether or not insurance benefits may have been received. One and one-half percent (1.5%) per month interest (18% per year) will be charged on accounts 60 days from treatment date.

Missed Appointments

Appointment times are reserved especially for you. If you come in late, the doctor may request that you reschedule the appointment and you may be charged a fee of $ 75. If for any reason you should need to change your appointment, there will be no charge provided you give 48- hour notice. Please help us serve you better by keeping your scheduled appointments. We are here to assist you in any way possible. Please make your question and concerns know to our team. Our goal is to ensure that you have an outstanding experience.

Signature (responsible Party) _____ financial coordinator _____ date

Bloomfield Dental Center
12657 166th Street
Cerritos, CA 90703
(562) 926-6502

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

* You may refuse to sign this Acknowledgement *

I _____ have received a

copy of this office's Notice of Private Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of Notice of Private Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____Communication barriers prohibited obtaining acknowledgement

_____An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please specify)

Patient Acknowledgment of Receipt of Dental Materials Fact Sheet

I, _____, acknowledge I have
Pint Name

Received from Bloomfield Dental Center a copy of the

Dental Materials Fact Sheet dated October 2001.

_____ _____

Patient signature Date

SAMPLE

The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet; and its linkage to the DCA web site does not constitute an endorsement of the content of this document

The Dental Board of California

Dental Materials Fact Sheet

Adopted by the Board on October 17, 2001

As required by Chapter 801, Statutes of 1992, the Dental Board of California has prepared this fact sheet to summarize information on the most frequently used restorative dental materials. Information on this fact sheet, is intended to encourage discussion between the patient and dentist regarding the selection of dental materials best suited for the patient's dental needs. It is not intended to be a complete guide to dental materials science.

The most frequently used materials in restorative dentistry are amalgam,composite resin, glass ionomer cement, resin-ionomer cement, porcelain (ceramic), porcelain (fused-to-metal), gold alloys (noble) and nickel or cobalt-chrome (base-metal) alloys. Each material has its own advantages and disadvantages, benefits and, and risks. These and other relevant factors are compared in the attached matrix titled "Comparisons of Restorative Dental Materials." A Glossary of Terms" is also attached to assist the reader in understanding the terms used.

The statements made are supported by relevant, credible dental research published mainly between 1993 - 2001. In some cases, where contemporary research is sparse, we have indicated our best perceptions based upon information that predates 1993.

The reader should be aware that the outcome of dental treatment or durability of a restoration is not solely a function of the material from which the restoration was made. The durability of any restoration is influenced by the dentist's technique when placing the restoration, the ancillary materials used in the procedure, and the patient's cooperation during the procedure. Following restoration of the teeth, the longevity of the restoration will be strongly influenced by the patient's compliance with dental hygiene and home care, their diet and chewing habits.

Email Form