MEDICAL HISTORY

Patient Name

(Patient Account No. Medical Alert

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? _____ Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? _____ Yes No
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? _____ Yes No
   If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)? _____ Yes No
   If yes, did you take any of the following? (circle if yes) Fen-Phen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues? _____ Yes No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? _____ Yes No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? _____ Yes No
   If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? _____ Yes No
8. Indicate which of the following you have had, or have at present. Circle "yes or "no"" toeach item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle) ...	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No			

9. Have you lost or gained more than 10 pounds in the past year? _____ Yes No
10. Do you have or have you had any disease, condition, or problem not listed? _____ Yes No
    If yes, please list: _____
11. **Women:** Are you pregnant or think you could be pregnant? Yes_____ Months No **Nursing?** Yes No
12. Do you use birth control prescriptions? _____ Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

Patient Name

Patient Account No.

Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today?

Date of Last Dental Visit **Last Dental Cleaning** **Last Full Mouth X-rays**

What was done at your last dental visit?

Previous Dentist's Name

Address State Zip

Telephone

How often do you have dental examinations?

How often do you brush your teeth? How often do you floss?

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.)

Do you have any dental problems now? Yes No

If yes, please describe:

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where?

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe

Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

If yes, please describe

(Please complete other side)

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1			
DATE			
LAST NAME	FIRST		M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.	FAX		
CELL	EMAIL		
BIRTHDATE	AGE		
MARRIED		DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE			
LAST NAME	FIRST		M.I.
ADDRESS			
CITY	STATE		ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2		
DENTAL INSURANCE		
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

3		
GETTING TO KNOW YOU		
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

4		
ACCOUNT INFORMATION		
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

Please turn over and sign

1.800.925.2600 www.prideinstitute.com

Smile Evaluation

A Simple Evaluation to Help You Obtain the Smile You've Always Wanted

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, and then answer the following questions:

1 Do you like the appearance of your teeth and your smile? □**Yes** □ **No**
If not, explain _____

2 Are your teeth all in alignment (straight)? □ **Yes** □ **No**
If not, explain _____

3 Do you have spaces that you don't like? □ **Yes** □ **No**
If yes, explain _____

4 Do you like the color of your teeth? □ **Yes** □ **No**
If not, explain _____

5 Do you like the shape of your teeth? □ **Yes** □ **No**
If not, explain _____

6 Are your teeth...
Chipped □ **Yes** □ **No** Protruding □ **Yes** □ **No** Hidden □ **Yes** □ **No**
If yes, explain _____

7 Are your teeth wearing on the biting surfaces? □ **Yes** □ **No**
If yes, explain _____

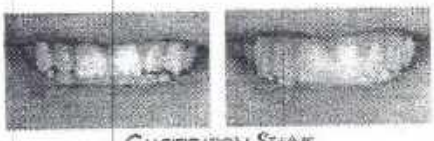
8 Are there old fillings or dental work you don't like looking at? □ **Yes** □ **No**
If yes, explain _____

9 What would you like to change the most in the appearance of your teeth?
_____

10 How would you like your teeth to look?
_____


STAINED AND CHIPPED


SPACES


CALCIFICATION STAINS


FANGED TEETH


STAINED AND CROOKED TEETH


PORCELAIN CROWNS


BEAUTIFUL SMILE

If you are not happy with the appearance of your teeth, ask your dentist how they can improve your smile.

LUMINEERS

snapon smile

duo PCH
Porcelain Composite Hybrid

CANCELLATION AND NO SHOW POLICY

THERE IS A $125 CHARGE FOR APPOINTMENTS THAT ARE NOT KEPT OR CANCELLED WITH LESS THAN 24 HOURS (1 BUSINESS DAY NOTICE)

YOU ARE RESPONSIBLE FOR THESE CHARGES. YOUR HEALTH INSURANCE POLICY DOES NOT COVER THIS FEE.

PLEASE TAKE THE TIME TO VERIFY YOUR APPOINTMENT WITH THE OFFICE. WE SEND REMINDER CARDS, EMAILS AND TEXT MESSAGES TO YOUR CELL PHONE TO CONFIRM YOUR APPOINTMENTS. PLEASE SHOW US THE COURTESY OF A PHONE CALL TO OUR OFFICE TO CONFIRM YOUR APPOINTMENT.

YOU NEED TO NOTIFY THE OFFICE IF YOU PLAN TO CANCEL OR CHANGE YOUR APPOINTMENT WHEN YOUR APPOINTMENT IS ON:

- **MONDAY—THE PREVIOUS THURSDAY BY NOON**
- **TUESDAY—THE PREVIOUS MONDAY BY NOON**
- **WEDNESDAY—THE PREVIOUS TUESDAY BY NOON**
- **THURSDAY—THE PREVIOUS WEDNESDAY BY NOON**

PATIENT SIGNATURE_____ DATE_____

E-MAIL_____ CELL PHONE_____

THANK YOU FOR YOUR UNDERSTANDING!

MARINA LANDING FAMILY DENTISTRY

ASMITA DHARIA, D.D.S

Acknowledgement of Receipt of Marina Landing Family Dentistry

Notice of Privacy Practices

Practice Doctor
Asmita Dharia, D.D.S
1050 Marina Village PKY. Ste:106
Alameda, Calif. 94501

Privacy Officer
Beth Allison
(510)523-8411

It is Marina Landing Family Dentistry and Asmita Dharia, DDS practice policy that patient treatment **NEVER** be conditioned on the signing of this acknowledgment of receipt of this Notice of Privacy Practices. In addition, no retaliatory action will be tolerated from staff in response to a patient's decision not to sign this acknowledgement.

By signing this document, I acknowledge that I have received a copy of the Marina Landing Family Dentistry and Asmita Dharia, DDS notice of privacy practices.

Signature _____ Date _____

Print full name _____

If not signed by the patient, please indicate:

Relationship:

_____ Parent or guardian of minor patient

_____Personal representative of an incompetent patient

Marina Landing Family Dentistry's
Notice of privacy practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Marina Landing Family Dentistry, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service.

We have written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method; number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information to you.

You have the right to see and receive a copy of your health information, with a few expectations. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509f, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). you will be retaliated against filing a complaint.

Please contact our Privacy Officer, Beth Allison, at (510)523-8411 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Patient-Dentist Arbitration Agreement

Article I.

It is understood that any dispute as to dental malpractice, this, as to whether any dental services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, would 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 of this contract by entering into it, have given 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.

Treatment in this office is contingent upon both parties consenting to this Arbitration Agreement.

Article II.

A. Parties to the agreement:

The term "patient" as used in this agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heir, assignee or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "doctor" as used in this agreement includes the undersigned doctor and his or her professional corporation or partnership, and any employees, agents, successors in interest, heirs and assigns of the foregoing individuals or entities and independent contractors. The doctor signing this agreement signs it on behalf of all the foregoing individual and entities, and intends to bind each of them to arbitration to full extent permitted by law.

B. Treatment Covered:

Patient understand and agrees that any dispute of the sort described in Article I between doctor and patient will be subject to compulsory, binding arbitration.

C. Coverage of Pre-Natal Claims (if Applicable):

Patient understands and agrees that, if doctor treats her during pregnancy, any dispute or sort described in Article I as to dental treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

Article III.

A. Informal Resolution of Disputes:

In the event patient feels that a problem has arisen in connection with the dental care rendered by doctor to patient, patient will promptly notify doctor so that doctor may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running or statute of limitations for ninety (90) days.

B. Method of Initiating Arbitration:

If the dispute is not resolved by mutual Agreement within ninety (90) days, patient may initiate arbitration by notifying doctor to that affect. The arbitrator shall be selected by the chief administrator of JAMS ENDISPUTE. The arbitrator must be selected within twenty-one (21) days of the signature on the receipt for a letter sent certified mail return receipt request demanding that a dispute submitted to arbitration. Following the selection of the arbitrator, arbitration must be held within thirty (30) days.

C. Applicable Law:

The arbitration shall be conducted pursuant the California Arbitration Act (C.C.P. 1280-1296). The arbitrator shall, in addition, have authority to order such other discovery as he/she deemed appropriate

for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California, including the provisions of the Medical Injury Compensation Reform Act 1975 which shall apply to the same extent as if to dispute or pending before a Superior Court of the State of California.

The arbitrator shall not have the power to commit errors of law or legal reasoning, and the arbitrator's decision may be vacated or corrected pursuant the California Code of Civil Procedure Sections 12806.2 or 12086.6 for any such error.

The prevailing party shall be entitled to attorney fees.

Article IV.

A. Revocation:

If you are signing this agreement and then change your mind, the law permits you to revoke the Agreement providing you give your doctor written notice within thirty (30) days of signing that you want to withdraw from the Agreement. However, doctor and patient agree that any claim arising for dental services rendered prior to revocation shall be subjected to arbitration. Furthermore, doctor is not obligated to continue the doctor/patient relationship should you decide to withdraw from the agreement.

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

PATIENT'S NAME: (Please print): _____

DATE: _____

SIGNED: _____

SIGNED: _____
Patient/Legal Guardian

SIGNED: _____
Witness