HEALTH HISTORY & REGISTRATION

PATIENT INFORMATION

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name_____ Date _____
First MI Last

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Work Phone _____ Home Phone_ _____

Birthdate_____ Social Security Number_____ E-Mail_____

Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

You or your parent's employer_____ Occupation_____
Business Address_____ City_____ State_____ Zip_____
Spouse's or parent's name_____ Workplace_____ Phone #_____
Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY

Name of person responsible for this account?_____
Relationship to patient_____ Phone number_____
Address_____ City_____ State_____ Zip_____
Name of employer_____ Work phone_____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company_____
Insured's Name_____ Birthdate_____
Insured's Employer_____ SS #_____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company_____
Insured's Name_____ Birthdate_____
Insured's Employer_____ SS#_____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU

Name_____ Relationship_____ Phone #_____
Address_____ City_____ State_____

DENTAL HISTORY

HOW LONG SINCE you have seen a Dentist?_____ Last COMPLETE Dental Exam Date:_____
Last FULL MOUTH X-RAYS Date:_____ Last PROPHYLAXIS (Teeth Cleaning):_____
Are you having any problems now?_____ WHAT?_____

INSURANCE CONSENT

I hereby authorize payment directly to Dr. Rosen of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization.

_____
Signed (Insured person or parent of minor) Date

INSURANCE CONSENT

I hereby authorize release of any information relating to any insurance claim, and I authorize Dr. Rosen and staff to sign insurance forms on my behalf.

_____
Signed (Insured person or parent of minor) Date

The undersigned hereby authorizes the Doctor to take the X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that my dental insurance is a contract between me and the insurance carrier and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge and interest will be added to any overdue balance, and I will be responsible for any and all costs for collection of this balance.

PATIENT Signature_____ Date_____ DENTIST Signature_____

*****There will be a charge for all missed appointments without 48-hour notice*****

MEDICAL HISTORY

Patient Name_____ **Date**_____

Do you have any CURRENT HEALTH PROBLEMS? Yes No
Are you under a PHYSICIAN'S CARE now? Yes No
For WHAT?_____

Women: Are you PREGNANT? Yes No
Are you NURSING? Yes No
Are you currently taking birth control? Yes No

Have you ever SMOKED? Yes No
Used CHEWING Tobacco? Yes No
Have you been hospitalized in the past 5 years? Yes No
Reason_____
What MEDICATIONS are you currently taking?_____
List any allergies to medications_____

M.D. Name_____ **Phone #**_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? Please circle Y for Yes or N for No.

Y N Heart Disease (MI)
Y N Heart Disease or Attack
Y N Angina Pectoris
Y N High Blood Pressure
Y N Heart Murmur
Y N Rheumatic Fever
Y N Congenital Heart Lesions
Y N Mitral Valve Prolapse
Y N Artificial Heart Valve
Y N Heart Pacemaker
Y N Heart Surgery
Y N Artificial Joints (Hip,Knee)
Y N H.I.V.
Y N A.I.D.S.
Y N Ever Taken Fen-Phen or Redux
Y N Hepatitis Type_____
Y N Liver Disease
Y N Do you take or have you ever taken Bisphosphonates (Fosamax,Boniva,Actonel,Aredia,Zometa,etc) for Osteoporosis or any other condition?

Y N Blood Transfusion
Y N Drug Addiction
Y N Hemophilia
Y N Fever Blister
Y N Epilepsy or Seizures
Y N Nervousness
Y N Psychiatric Treatment
Y N Bleeding or clotting disorders
Y N Herpes (Cold Sores)
Y N Bleeding Problems
Y N Bruise easily
Y N Emphysema
Y N Tuberculosis (TB)
Y N Asthma
Y N Hay Fever
Y N Sinus Trouble
Y N Allergies or Hives

Y N Diabetes
Y N Thyroid Disease
Y N Radiation Treatment
Y N Chemotherapy
Y N X-ray Treatment
Y N Cosmetic Surgery
Y N Alcoholism
Y N Glaucoma
Y N Kidney Trouble
Y N Stroke (CVA)
Y N Anemia
Y N Arthritis
Y N Pain in Jaw Joints (TMJ)
Y N Venereal Disease (Syphilis,Gonorrhea)
Y N Allergic to Latex
Y N Allergies
If YES, to what?_____

Patient Signature_____ Staff Review_____

HEALTH HISTORY UPDATE Date:_____

Current Medications:_____
Health Changes:_____
Patient Signature:_____ Staff Review_____

HEALTH HISTORY UPDATE Date:_____

Current Medications:_____
Health Changes:_____
Patient Signature:_____ Staff Review_____

HEALTH HISTORY UPDATE Date:_____

Current Medications:_____
Health Changes:_____
Patient Signature:_____ Staff Review_____

INFORMED CONSENT-OFFICE POLICY

I hereby request and authorize the Dentists and their staff to perform dental work or treatment upon me for the purpose of improving my dental health, including the health and/or appearance of my teeth, gums, and mouth. I understand that results cannot be guaranteed. I understand that it is my responsibility to inform the Dentist if I am having problems during or after dental treatment so as to allow him/her to help minimize any problems. I have been informed regarding the following common dental procedures and office policies:

1. DRUGS AND MEDICATIONS may cause reactions including, but not limited to, itching, swelling, pain, fever, achiness, vomiting, stomach upset, drowsiness, dizziness, rapid heart rate. Rarely, anaphylactic shock (severe allergic reaction) may occur.
2. LOCAL ANESTHETICS may cause itching, pain, swelling, fever, vomiting, dizziness, rapid heart rate, stomach upset, drowsiness, muscle spasm, internal bleeding ("black and blue" areas) in the lip, cheek or jaw, prolonged anesthesia(numbness) or paresthesia (tingling) in the lip, cheek, jaw or tongue, infection, muscle spasms. Rarely, anaphylactic shock (severe allergic reaction) may occur.
3. FILLINGS may cause mild tooth or gum sensitivity, which usually subsides in a few days or weeks. Rarely, sensitivity may persist or worsen, and may cause the need for root canal treatment. Also on occasion, the bite may become uncomfortable and may need adjustment.
4. CROWNS (CAPS) AND BRIDGES may cause mild tooth or gum sensitivity, which usually subsides in a few days. Rarely, sensitivity may persist or worsen, and may cause the need for root canal treatment. It is not possible to match the color of natural teeth perfectly. Temporary crowns may loosen or come of, and it is important to have them re-cemented as soon as possible, and to avoid sticky or hard foods. Occasionally the bite may become uncomfortable and require adjustment of opposing teeth.
5. PERIODONTAL (GUM) TREATMENT may cause tooth or gum sensitivity, which usually subsides in a few days. Rarely, sensitivity may persist or worsen, or there may be itching, pain, swelling, infection, anesthesia (numbness), paresthesia (tingling) or internal bleeding ("black and blue" areas) in the lip, cheek, jaw or tongue. Periodontal treatment cannot be guaranteed.
6. EXTRACTIONS (TOOTH REMOVAL) occasionally may cause severe pain, infection, swelling, fever, spread of infection, anesthesia (numbness), paresthesia (tingling) or internal bleeding ("black and blue" areas) in the lip, cheek, jaw or tongue, muscle spasm, "dry socket", bone (jaw) fracture, tooth fracture, fracture or loss of fillings, crowns and bridges, and increased difficulty with dentures (including increased looseness and denture irritation).
7. ROOT CANAL TREATMENT (RCT) occasionally may lead to pain, itching, swelling, fever, infection, anesthesia (numbness), paresthesia (tingling) or internal bleeding ("black and blue" areas) in the lip, cheek or jaw, tooth fracture, or tooth loss. Although RCT is usually successful, there can be no guarantee that a tooth will be saved. Also, after RCT the tooth must be restored with a filling or crown, at extra cost. Success cannot be guaranteed.
8. DENTAL WORK TAKES TIME, and may require more time and/or office visits than originally planned.
9. CHANGES IN THE TREATMENT PLAN is sometimes necessary. This may affect the overall cost of treatment and that of individual procedures, and it may alter the time required to complete treatment. Any estimate of treatment cost is based on the completion of all of the treatment included in the plan. Any alteration of the plan may affect the cost of other items on the plan.
10. X-RAYS are a necessary adjunct to diagnosis and treatment. We make every effort to minimize radiation, and we believe that the exposure from dental X-rays is nil. Pregnant women and anyone concerned about radiation may wish to consult their physician prior to taking X-rays.
11. DENTURES AND PARTIAL DENTURES, new, repaired, relined or adjusted, cannot be guaranteed regarding comfort, fit, function or cosmetics. Any denture procedure may require numerous adjustments, and denture adhesive may be needed.

GENERAL OFFICE POLICIES:

PAYMENT IN FULL IS REQUIRED FOR ALL SERVICES AT THE TIME OF APPOINTMENT, unless prior written arrangements have been made. Please familiarize yourself with your dental insurance or dental plan (HMO).
Dental insurance and dental plan eligibility and payment of benefits are the responsibility of the patient.
PLEASE: Let us know of any changes regarding your dental insurance or dental plan (HMO) since your last visit.
There will be an additional $10.00 monthly fee charged if billing is requested or required, and an additional 1% /month service charge on all balances due over 30 days. We are pleased to accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARECREDIT for all payments.
There may be a 15% service charge (minimum $35.00) for returned checks and credit card reversals.
PLEASE: NO SMOKING, FOOD, OR DRINK IN THE OFFICE.
PLEASE: CELL PHONES MAY ONLY BE USED IN THE WAITING ROOM.
PLEASE: BE ON TIME. If you are more than 15 minutes late there may be a late fee and/or we may not be able to complete all of the work planned for your appointment. The amount of this fee may be $20-$200 or more.
There is normally a charge for missed appointments without 48 hours notice (2 business days, excluding weekends). Depending on the appointment type and length, this charge may be $20-$200 or more.
Homecare products may be returned within 24 hours of purchase, if unopened. There is a 15% restocking fee.
PLEASE: LET US KNOW IF ANY CHANGES REGARDING YOUR MEDICAL HISTORY ON EACH VISIT.

I acknowledge that no guarantee or assurance can be made regarding any dental work or treatment.
I hereby authorize the release of my dental records to my insurance company, dental plan, or other health care providers, as deemed necessary by the Dentist and/or staff.
I certify that I have received a copy of the Dental Materials Fact Sheet (Calif. Board of Dental Examiners).
I certify that I have received a copy of the Dental Records Are Confidential (HIPPA).
I certify that I have read the above and understand it, and that I agree to comply with the general office policies. I hereby request and authorize the Dentist and Staff to proceed with treatment.

Signature_____ Date _____ Staff _____

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 service rendered under this contract were unnecessary or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit to 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 rights to have any such disputes decided in a court of law before a jury, and instead are accepting the use of arbitration. The result of any such arbitration shall be binded and non appealable.

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 to relate to treatment or service provided by the dentist including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term, "patient" herein shall mean both the mother and the mother's expected child or children. All claims for 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 to 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 a court by the dentist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. Any such arbitration shall be filed with the American Arbitration Association located in Los Angeles, California.

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 of a demand for a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rate share of the expense and fees of the neutral, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expense incurred by a party for such party's own benefits. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issue of liability and damages upon written request ot 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 provisions of California law applicable to health care providers shall apply to disputes with this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 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 Procedures.

Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken with prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same, incident, transaction or related circumstance shall be arbitrated in one proceeding. A claim 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 stature of 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 arbitrators shall be governed by the California Code of Civil Procedure provisions relation to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the dentist within 30 days of signature. It is the intent of this agreement to apply to all dental services rendered anytime for any condition.

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 to 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 YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.
SEE ARTICLE 1 OF THIS CONTRACT.

By:_____
Dentist's or authorized Representatives Signature (Date)

Classic Dentistry,INC &Associates

By:_____
Patient or Patient Representative's Signature (Date)

By:_____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

PERSONALIZED SMILE AND HEALTH EVALUATION

Name_____ Age_____ Today's Date_____

Please answer the following questions. Your answers will allow us to develop a plan to help you obtain the smile and health we all want.

1.	Do you show too much gum when you smile?	Yes	No
2.	Do you have noticeable gum recession?	Yes	No
3.	Do you have spaces between your teeth that bother you or are changing?	Yes	No
4.	If your teeth are crooked or crowded, does that bother you?	Yes	No
5.	Are your teeth protruding or shifting?	Yes	No
6.	Are you aware of clenching or grinding your teeth?	Yes	No
7.	Do you have clicking jaw joints, frequent headaches, neck aches or uncomfortable chewing?	Yes	No
8.	Did any of your relatives lose their teeth due to gum or bone disease?	Yes	No
9.	Have you ever experienced any of the following?	Yes	No

bleeding gums	pus around the teeth
foul odor	swelling of gums
loose teeth	bad breath or bad taste
pain or soreness	spaces between teeth
receding gums	drifting of teeth
high or rough fillings	food packing between teeth

10.	Are you aware that continued untreated gum disease has a strong link to HEART DISEASE?	Yes	No
11.	Are you aware that continued untreated gum disease has a strong link to DIABETES?	Yes	No
12	Are you aware that continued untreated gum disease has a strong link to RESPIRATORY DISEASE?	Yes	No
13.	Are you aware that continued untreated gum disease has a strong link to PRE-TERM, LOW BIRTH WEIGHT BIRTHS?	Yes	No
14.	Are you aware that continued untreated gum disease has a strong link to OSTEOPOROSIS?	Yes	No

Classic Dentistry inc, & Associates

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Woodland Hills, CA 91364
818-999-6165 Fax 818-598-2198

Optional Treatment Form and Informed Consent for Removal of Silver-Mercury (Amalgam) Fillings

A recent (2016) scientific study from the University of Georgia, Department of Environmental Health Science in the College of Public Health has indicated, for the first time, that Silver-Mercury fillings cause increased blood mercury levels and therefore may constitute a serious general health hazard. Many more studies are needed to confirm these findings.

While Silver-Mercury fillings function well for many years, they have long been known to cause tooth fracture after 10-15 years of service, because they corrode and expand over time, and often root canal treatment, gum surgery, and/or crowns are needed to restore these teeth. Occasionally, teeth with Silver-Mercury fillings cannot be restored and must be extracted.

Silver-Mercury fillings may be safely removed and replaced with non-metallic (tooth colored) fillings or non-metallic (tooth colored) porcelain crowns.

Silver-Mercury fillings are removed using a special technique that eliminates mercury from the mouth by first isolating the metal with a latex dam and then high-speed vacuuming it away. This technique effectively prevents any mercury or silver from entering the body.

Immediately after the old Silver-Mercury fillings are removed they are replaced with non-metallic fillings or crowns, which contain no silver or mercury, or any other metals.

Side effects of this procedure are rare, and are the same as the side effects for all fillings and crowns. They include tooth sensitivity, pain, gum irritation, tooth fracture, tooth breakage or cracking, swelling of the gums, lips, cheeks and other soft tissues in the mouth, and allergic reactions. All of these side effects may be treated. On very rare occasions, root canal treatment, gum surgery, or extraction of the tooth may become necessary. Side effects may increase time needed to complete treatment and the cost of treatment.

At this time, the cost of replacement of Silver-Mercury fillings with non-metallic fillings and crowns is considered by insurance companies to be cosmetic, and is a non-covered benefit. Patients are responsible for the entire cost of replacement of Silver-Mercury fillings and the cost of treatment of any side effects that may arise from that replacement.

Costs: Porcelain Crown - $ 1,250 Tooth Colored Filling - $250 - $450 (Depending on size)

I have read, understand and agree to all of the above terms, and accept full responsibility for all costs associated with treatment.

_____ _____

Patient/Guardian Date

MAINTENANCE OF DENTAL IMPLANTS

Implants require special care. They must be cleaned every 4-6 months, and specially designed plastic instruments must be used to remove hard calcium deposits, bacteria and debris from the collar of the implant without scratching or nicking the titanium-oxide surface of the implant. Additionally, the crown or abutment that is attached to the implant must be cleaned of hard calcium deposits as well. If implants are not cleaned properly, calcified bacterial deposits and live bacteria will accumulate in the area where the gum tissue touches and attaches to the implant, leading to inflammation of the tissues surrounding the implant and recession of the bone around the implant. This process, if not corrected, will lead to loss of bone support around the implant, inflammation and infection of tissues around the implant, and eventually the loss of the implant.

Implant maintenance is routinely performed at the time of your teeth cleaning (prophy) or periodontal maintenance visit. The California Board of Dental Examiners, the California Dental Association Code of Ethical Conduct and the Standard of Care in the State of California all require that IMPLANT MAINTENANCE be completed in conjunction with your regular teeth cleaning.

Dental Plans:

PPO: TEETH CLEANING and DENTAL IMPLANT MAINTENANCE are both covered benefits on most PPO dental plans, with a small extra cost (copayment) required.

HMO: TEETH CLEANING (PROPHY) (PROPHYLAXIS) (CDT CODE# 1110) is a covered benefit on all HMOs. There may be a small extra cost (copayment) required.

HMO: IMPLANT MAINTENANCE (CDT CODE# 6080) is listed on HMO dental plans as an EXCLUSION, and therefore it is NOT covered. (See LIST OF EXCLUSIONS)

The cost of IMPLANT MAINTENANCE + TEETH CLEANING (PROPHY) is $88.00

Do you have one or more DENTAL IMPLANTS? Yes/No How many? _____

If Yes, in what area is your DENTAL IMPLANT? Upper/Lower Left/Right

_____ _____

Signature Date

Information To Our Patients

Our mission is to deliver the finest, most cost effective dental care available today. Following diagnosis the doctor will discuss with you our plan for treatment. We will also discuss the cost of today's and future treatments. Payment for all services is due at the time of treatment. Because your dental plan may not cover the entire cost of your treatment, we offer several alternative payment options for your convenience.

Payment Options

1. Cash or Check

2. MasterCard or Visa

3. Monthly Payment Plan - The monthly payment is a separate line of credit for dental care only. It does not require payment now, nor the use of your bank credit cards, leaving them free for non-healthcare purchases and emergencies. It does not affect the balance of your other credit cards, and there are no annual fees. Monthly payments can be as low as 3% of your outstanding balance. For example:

Balance	Monthly Payment	Balance	Monthly Payment
$ 500.00	$ 15.00	$2,000.00	$ 60.00
$1,000.00	$ 30.00	$4,000.00	$120.00

Please indicate below the payment option you wish:

[ ] **Cash or Check**

[ ] **Visa or MasterCard**

[ ] **Monthly Payment Plan** - If you choose this option, we will help you complete the simple application, and processing will only take a few minutes.

Signature of Patient/Responsible Party _____ Date _____

7/97

About Your Dental Plan (HMO or PPO)

Thank you for choosing our office to provide your dental health care. We are dedicated to providing all of our patients with the finest dental care possible, in a compassionate and caring environment.

As a patient, you are responsible for all fees for services rendered while under your Dental HMO (Plan), and it is your responsibility to understand and follow all applicable Plan RULES and GUIDELINES. Our office will be pleased to help if your Plan or insurance agent has not provided this information. Your Dental HMO (Plan) will help reduce your overall dental costs, starting on your first visit. Your CO-PAY (the amount you pay) for your first visit, including x-rays, exam and routine cleaning, will be 0-$20, saving you approximately $200.

The RULES and GUIDELINES of your Plan include BENEFITS, LIMITATIONS and EXCLUSIONS:

BENEFITS:

Office visits: There may be a CO-PAY for office visits, in addition to any service provided, of $5-$20.
Cleanings: Routine cleanings are covered. There may be a CO-PAY of $10-$30.
Cleanings with IMPLANTS: Implants require special MAINTENANCE, which is not a BENEFIT.
The CO-PAY for Cleanings with Implants is $88.
Implants: Implants, Implant Crowns and Implant Maintenance are not BENEFITS.
BENEFITS that are partially covered include Crowns, Fillings, Gum Treatment, Dentures, Partial Dentures, and Extractions. These BENEFITS require a CO-PAY and are usually covered at 20%-80%.
All BENEFITS are listed in your Plan booklet

EXCLUSIONS (Services that are not covered):

Cleanings with Implants (Implant Maintenance)
Cosmetic services or services done primarily for cosmetic (not functional) purposes
Crowns when teeth can be filled or when teeth are very weak
Any services that will not improve your dental health or are not recommended by the dentist
Services that are considered very complex, sophisticated or extensive
Services considered unlikely to have long term success
Home care products such as toothbrushes, dental floss, mouth rinses
All EXCLUSIONS and LIMITATIONS (of BENEFITS) are listed in your Plan booklet.

RULES and GUIDELINES:

Prior to starting treatment our doctors and staff will explain treatment options, benefits and risks, costs, and applicable Plan RULES and GUIDELINES, and will obtain written authorizations/verification of fees by the Plan if requested. Pre-authorization may delay the start of treatment and does not guarantee accuracy of fees or payment by the Plan. Patients are responsible for all costs for all services rendered while eligible under the Plan.

I have read and understand the above and agree to abide by all of the RULES AND GUIDELINES of my Plan.

_____ _____

Signature Date

_____

Print Name