We are committed to excellence in Orthodontics and appreciate you taking the time to complete this confidential questionnaire.
The better we communicate, the better we can care for you.

Patient Information

Patient's Name: First: _____ Last: _____ DOB: _____

Home Address: _____ City: _____ Zip: _____

Email: _____ Mobile: _____ Alt #: _____

Patient's School/Work: _____ Patient's General Dentist _____

Accompanying Parent/Guardian: First: _____ Last: _____

Email: _____ Phone: _____

About You

Do you play sports? If yes, which sports do you play? _____

What are your hobbies? _____

Do you like the way your teeth and smile look? (please explain) _____

Which treatment method are you most interested in?

☐ Braces ☐ Clear Braces ☐ Damon ☐ Invisalign ☐ Lingual ☐ Not Sure

Responsible Party Information

Name: First: _____ Last: _____ DOB: _____

Home Address: _____ City: _____ Zip: _____

SS#: _____ Email: _____

Home Phone: _____ Mobile_____ Work Phone: _____

Relationship to Patient: _____ Marital Status: Single | Married | Divorced | Separated

Employer: _____ Occupation: _____

Dental Insurance Information

Primary Dental Insurance:

Policy Holder's Name: First: _____ Last: _____ DOB: _____

Employer: _____ Insurance Agency: _____ Policy #_____

Secondary Dental Insurance:

Policy Holder's Name: First: _____ Last: _____ DOB: _____

Employer: _____ Insurance Agency: _____ Policy #_____

New Patient Registration

Medical History

Does the Patient have or has the Patient ever had:

	Yes	No		Yes	No
Heart Problems	☐	☐	Autism	☐	☐
Abnormal Blood Pressure	☐	☐	Cleft Lip/Palate	☐	☐
Anemia/Abnormal Bleeding	☐	☐	Diabetes	☐	☐
Asthma	☐	☐	Seizures/Epilepsy	☐	☐
Lung Disease/Tuberculosis	☐	☐	Frequent Headaches	☐	☐
Osteoporosis/Bone Disorder	☐	☐	Hepatitis	☐	☐
ADD/ADHD	☐	☐	HIV/AIDS	☐	☐

Allergies on:

Latex	☐	☐	Other: _____
Nickel	☐	☐	_____
Local Anesthetics	☐	☐	_____

Dental History

Does the Patient have or has the Patient ever had:

	Yes	No		Yes	No
Tooth Trauma or Injury	☐	☐	Oral Surgery	☐	☐
Periodontal or "Gum Disease"	☐	☐	Use tobacco products	☐	☐
Pain in Jaw Joints or "TMD"	☐	☐	Visited an orthodontist before	☐	☐
Pain or Soreness around your ear	☐	☐	Had Orthodontics Treatment	☐	☐
Lung Disease/Tuberculosis	☐	☐	Other Family members treated here	☐	☐
Difficulty or Pain while Chewing	☐	☐			

How Did You Hear About Us?

☐	Dental Provider	☐	Instagram	☐	Internet Search
☐	Dental Insurance	☐	Facebook	☐	Family/Friend: _____
☐	Walk-in	☐	Yelp	☐	Other: _____

Who may we thank for referring you to our office? _____

I understand that the information I have given on this form is accurate and I am obligated to inform 360 Orthodontics of any future changes. I understand that where appropriate, credit reports ("soft inquires") may be obtained. I authorize 360 Orthodontics to provide my heath care information to other health care providers. I hereby consent to the making of diagnostic records, including x-rays, before, during, and following orthodontic treatment by 360 Orthodontics and, where appropriate, staff providing orthodontic treatment as prescribed by Dr. Partovi.

_____	_____	_____
Printed Name of Patient (Parent/Guardian)	Signature of Patient (Parent/Guardian)	Date

HIPAA CALIFORNIA NOTICE FORM

This notice describes how medical and Dental information about you may be used and disclosed, and how you can have access to this information.

1. **Disclosures for treatment, payment and healthcare operation.**
   We may use or disclose your protected health information (PHI), for certain treatment, payment, and healthcare operation purpose without your authorization. In certain circumstances we can do so when the person or business requesting your PHI gives us written request that include certain promise regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:
   - "PHI" refers to information in your health record that could identify you.
   - "Treatment and payment operation"
   - "Treatment" is when we or another healthcare provider diagnose or treat you. An example of treatment would be when we consult with another health care provider such as your physician or another dentist regarding your treatment.
   - "Payment" is when we obtain reimbursement for our service, an example of payment is when we disclose your PHI to your health insurance to obtain reimbursement for your health care or to determine your eligibility or coverage.
   - "Healthcare Operation" is when we disclose your PHI to your health care service plan, (for example your health insurer, or your other health care providers contracted with your plan for administering the plan such as management and care coordination.
   - "Use" applies only to activities within our office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
   - "Disclosure" applies to activities outside our office, such as releasing, transferring, or providing access to information about you to other parties.
   - "Authorization" Means written permission for specific use or disclosure.

2. **Use and Disclosure requiring authorization:**
   We may use your PHI for purposes outside treatment, payment, and health care operation, when your appropriate authorization is obtained. In those instances, when we are asked for information for purpose outside treatment, payment, and health care operation, we will request your authorization prior to forwarding your PHI to them.

3. **Health Oversight:**
   If a complaint is filed against us with the California Dental Board, the Board has authority to subpoena your PHI and dental record relevant to the complaint.

4. **Judicial or Administrative Proceedings:**
   If you are involved in a court proceeding and a request is made about the professional services that we have provided to you, we will not release your information without:
   a. Your written authorization or authorization of your attorney or personal representative.
   b. Court order.
   c. A subpoena ducas tecum (a subpoena to produce records). When a party seeking records provides our office with a showing that you or your attorney have been served a copy of the subpoena, affidavit and the appropriate notice, and you have not notified us that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party of when evaluation is court ordered. We will inform you in advance if this is the case.

5. **Workers Compensation**
   If you file a worker's compensation claim, we must furnish a report to your employer, incorporating our findings about your injury and treatment, within five days from the date of your initial examination, and at subsequent intervals as may be requires by the administrative director of the Worker Compensation Commission. In order to determine your eligibility for workers compensation.

I hereby authorize the use or disclosure of my protected health information as described below. I understand and acknowledge the following:

I am authorizing my protected health information to be used or disclosed as permitted by Federal Privacy Regulation.

- I may inspect or receive a copy of my personal health information
- My Doctor will not condition my treatment or payment for my treatment on obtaining this authorization from me.
- I have the right to revoke this authorization at the time. My revocation must be in writing and submitted to my doctor. My revocation will not affect any prior action taken by my doctor on reliance on my authorization.

Patient/Guardian: _____ Date: _____

Treatment and Arbitration Agreement

With regards to Dental care and services provided by 360 Orthodontics, it is agreed that the attending dentist will provide dental care and service to the patient to the best of their skill and knowledge. Possible and practical dental care will be determined in light of the patient's individual circumstances. It is agreed that because of differences in human constitution and response, it is no way possible to warrant the outcome of any medical or dental service provided.

It is understood that any dispute as to medical malpractice or whether any dental service rendered under this contract were unnecessary, unauthorized or were improperly, negligently, or incompetently rendered will be determined by submission to arbitration as provided by California law. Both parties waive their right to settle their disputes in a court of law before a jury and, instead, are accepting the arbitrator's decision. Within fifteen days after a PATIENT or ATTENDING DENTIST shall give notice to the other demanding arbitration of such controversy, each party of the controversy shall appoint a licensed dentist as an arbitrator and give such appointment to the other. Within a reasonable time the two arbitrators shall select another licensed dentist as a third arbitrator. The arbitrators shall hold a hearing within a reasonable time. All notices or other papers required to be served shall be served by United States mail. The arbitration shall be conducted in accordance with and governed by the provision of Title 9 of the California Code of Civil Procedure.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUES OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Patient Name: _____

Patient: _____ Date: _____
Signature

Responsible Party Name: _____

Responsible Party: _____ Date: _____
Signature

Patient Understanding and Consent

This is an important document which spells out many of the terms of the agreement between this office and you relating to your dental treatment. Please read this agreement carefully and, only if you agree, sign it at the end where indicated. Feel free to address any questions to the office manager or your dentist.

Consent for Dental Procedures: By signing this agreement, you are signifying that you understand and consent to receiving dental treatment from the office identified above. Before you receive treatment you are encouraged to ask your doctor about the procedure he/she recommends for you. We urge you and agree to ask any questions you might have before you decide to give your consent for treatment. All dental procedures may involve risks or unsuccessful results and complications, and no guarantees are made by the dentist or the dental office staff regarding any result or cure. We want you, as our patient, to be informed of any such risks and potential consequences of not performing treatment, the nature of the procedure, expected benefits, and availability of alternative methods of treatment. You are not required to consent to this treatment. You are free to refuse any proposed procedure at any time prior to its performance. The doctor/dental office also reserves the right not to perform specific treatment requested by a patient.

Health Status and Medications: You agree to inform your dental provider promptly if you have any changes in your health status or changes in your medicines. If you are taking a type of drug called bisphosphonate, which includes the trade names Fosamax, Actonel, Boniva, Didronel, Aredia, Zometa and Bonefos, you may be at risk of developing osteonecrosis (bone death) of the jaw, which is a very serious and damaging condition that could result in permanent injury, disability and even death. Certain dental treatment may increase this risk. **If you are taking any of these drugs you must immediately notify your dental provider**.

X-rays: Dental x-rays will be taken as necessary and appropriate for examination, diagnosis, consultations, and treatment. By signing this agreement, you give your consent to having these x-rays taken**.**
Women only: you must notify your dental provider if you are pregnant prior to any x-rays taken or dental procedure performed.

Photographs: Patient photographs may be taken to document a clinical condition and to record examination findings. By signing this agreement, you give your consent to having these photographs taken and utilized by your dental provider.

Keeping your appointment: You are required to be on time for your appointment. A 24 hour advance notification is required for all cancellations. You agree and understand that a cancellation fee may apply if the notice of cancellation if given less than 24 hours before the appointment is missed.

Patient's Financial Responsibility: You agree that by signing below, you will be financially responsible for 100% of the charges incurred. A fee will be provided before beginning treatment. Patients must also provide personal identifications for themselves or their children. This information may include social security numbers and other identifying information in order to process dental insurance claims and/or to request patient record information. As a courtesy to the patient with dental insurance the office will submit claims to the insurance company, however, the patient shall be responsible for all payments if the insurance company or other payor rejects, declines, doesn't cover the procedure, or any other reason does not provide payment, including, but not limited to, any or all of the following reasons:

1. Treatment goes over the insurance company's yearly maximum benefit;
2. The patient is not eligible for insurance;
3. The insurance benefit is less than what was indicated by the estimated fee;
4. Payment is prevented or delayed because the patient has not complied with the request for insurance forms and signatures;
5. The patient does not complete treatment which results in non-payment by the insurance company;
6. Lab costs are incurred due to patients failure to appear at the appointment;
7. 7.The patient receives insurance checks and does not give the check to the dental office.

Assignment of Insurance Benefits: You agree to sign to the dental office, the benefits of all insurance claims made for the services rendered by the dental office. You further agree that all third party reimbursement for the work done at the dental office belongs to the dental office. If a check is received for such work by the patient, you agree to endorse and provide the check to the office within 5 business days. If you fail to do so, you understand and agree that your account may be turned over to debt collectors.

Interest and Collection: You agree that all amounts not paid within 30 days of billing, for any reason, shall bear interest at the rate of 10% per year until paid, plus a collection file set-up fee of 10% of the amount unpaid. You also agree to be responsible for all collection expenses in addition to the original payment amount due, excluding attorney fees and court costs.

Dental Records: You agree that the dental records, x-rays, photographs, models, and other diagnostic aids that relate to your treatment, shall be the property of the dental office. You have the right to inspect these aids and/or request a copy of them. You agree that the office may charge a reasonable administrative fee for this service and for the cost of copying materials.

Email and Telephone: You agree that the office may contact you via email and telephone. By providing the dental office your phone number and email address, you consent to receiving auto dialer and prerecorded message calls as well as text message and emails from the dental office or its third party associates and debt collector. If you would like to be taken off the email list you are required to complete, sign and submit an "email removal request' form to the office manager and obtain and retain a written receipt confirming that such form was submitted to the office.

Grievances and disputes: In the event of any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently such as the local Dental Society or California State Consumer Affairs Board of Dental Examiners, and you agree that you will accept their resolution in lieu of pursuing remedies by way of litigation. Both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a judge, and instead are accepting the decision of the reconciliation board of the local Dental Society or California State Consumer affairs board of Dental Examiners. This agreement is also binding on the heirs of the patients and all other family members.

Release: You hereby agree to release, hold harmless and waive all claims, losses, or damages resulting or relating to the treatment rendered hereunder by the dentist, dental assistant, owner of practice, or any staff member of the above-named office.

In the event any provisions or part of this agreement is later found to be null or void, the other provisions of this agreement and all parts thereof shall remain valid enforceable.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND AGREES TO THE FOREGOING, AND IS THE PATIENT OR THE PARENT OR GUARDIAN OF THE PATIENT WITH AUTHORITY TO GIVE CONSENT, OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE ACCEPT ITS TERMS.

Patient Name: _____

Patient/Legal Guardian Signature: _____ Date: _____

Release Form for PR, Print and Video Testimonials

I hereby give **360 Orthodontics** and those acting pursuant to its authority, permission to publish my testimonial interview, video and photograph.

I hereby authorize **360 Orthodontics** to:

1. Use my name, interview, photograph and testimonial in connection to any press, media release news article, collateral material, video or video testimonial.

2. Use my name and biographical material in connection with the same.

3. Publish or distribute the testimonial through print, video, multi-media or any other advertising mediums in whole or in part without restrictions or limitations for any educational and non-commercial purpose which **360 Orthodontics** and those acting pursuant to its authority, deem appropriate; and …

4. To copyright the same in its name or any other name it may choose.

I hereby release and discharge, its successors and assigns, its officers, employees and agents, from any and all claims and demands arising out of or in connection with the use of such information, including photographs, film or tape, including but not limited to any claims of defamation or invasion of privacy.

I hereby consent to the release of said interview, testimonial and photograph or any other medium for the above-stated purposes.

PATIENT NAME: _____

SIGNATURE (Parent/Guardian if Patient is under 18):

_____ DATE_____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____