CDIDentalGroup
EMBRACE YOUR SMILE

Patient Name: _____ **Referred by:** _____

Phone: _____ **Date of Birth:** _____ **SSN:** _____

Address: _____ **City:** _____ **Sate:** _____ **Zip:** _____

E-Mail: _____

On-line scheduling available long on: BRACESLB.CHECKAPPOINTMENT.COM

Our Goal

Our goal is to offer you exceptional service in a relaxing and modern facility. Providing your dental care with the objective of augmenting and sustaining overall good health is our number one priority.

The following important guidelines of our facility allow us to focus on efforts and expertise toward our goal by offering you the best in dentistry. Our highly trained staff is prepared to make your visit a very positive and caring experience. Please, do not hesitate to ask us any questions that you may have pertaining to our service.

Thank you for your confidence in us. We look forward to serving you.

Concierge Service

To ensure efficient and professional care for our patients, we operate on a system of scheduled appointments. We value time and understand that life can be busy, so we provide our patients with full "concierge service" which includes a prompt response time for all questions, concerns or appointment scheduling. Please call (562)317-5258 or e-mail contactus@cdidentalgroup.com and our team will be happy to assist you with scheduling. We do encourage you to set your appointment in advance so that the time that best suits your needs can be reserved. You can also visit our website at cdidentalgroup.com or our Facebook page. We will always do our best to respond quickly to you.

Appointment Cancellations and Deposit Policy

At all times we have a listing of patients who are requesting specific time slots. In order to accommodate our entire family of patients scheduling requests to the best of our ability, we ask you to honor our 48 hours rescheduling policy.

We strive to render excellent dental care to you and rest of our patients. In an attempt to be consistent, we have an Appointment Cancellation and Deposit Policy that allows us to schedule appointments of all the patients.

When an appointment is scheduled, that time has been set aside specially for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

- When require that you give our office a 48-hour notice in the event that you need to reschedule your appointment. This allows for other patients to be contacted and scheduled into that appointment.
- If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee will be charged to you; this fee cannot be billed to your dental insurance company and will be your direct responsibility.
- Patients will also be required to submit a deposit of $100 which will be used towards your dental treatment to confirm your appointment. If the appointment is missed or cancelled within less than 48hours, the patient will forfeit the deposit.
- A grace period of 10 minutes will be allotted to all patients, if a patient is late more than 15 minutes to their appointment, they will be charged a missed appointment fee and will be rescheduled.

If you have any questions regarding this policy, please let our know and we will be glad to clarify any questions you may have.

Multiple missed appointments or rescheduled appointments could result in suspension of all dental and orthodontic services and dismissal from our dental practice.

Braces "Monthly Fee" / Hygiene visit $80 / General Dentistry $100

I have read and understand the Appointment Cancellation and Deposit Policy of the practice and I agree to be bound by its terms.

I, _____ (print name), have received a copy of the appointment Cancellation Policy and agree with the policy as well as understand that I may not be able to schedule future appointments unless fees are collected.

_____

Signature **Date**

Fees and Payments

Our fees are based on the current American Dental Association fee guide. Full payment for each phase of your treatment is required at the time of your appointment. For your convenience, we accept cash, MasterCard, Visa, America Express or Discover Payments. We also offer a payment plan through the Lending Club or CareCredit. For more information ask our front office.

Insurance

If you have dental insurance benefits, we will gladly submit a claim for services rendered on your behalf, to assist in prompt payment from your insurance company.

We will process your claim electronically. Proof of insurance will be requested at the time of each appointment. If your insurance provider changes, please let us know so that we may keep our records up to date and current.

Please note that your insurance policy is an agreement between you, your employer and the company providing the benefits, the insurance company will submit payment to our office for the converge in your particular plan, and you will be required to pay your estimated portion at the time of service.

Insurance companies vary greatly in compensation. They most often cover the most basic or even the least expensive form of treatment. Our goal is to provide you with the best treatment available and therefore we shall always give you our recommendations for the best treatment. The best recommendation may not always be covered by your insurance policy. Please keep this in mind when you are making your decision for lifelong dental care. When the policy does not cover what we recommend, only you as the patient have the right to decide whether you want to go forward with the treatment options that is the best for your health, or the treatment option that the insurance company covers but not result in the best possible outcome.

I have read and understood the office policy descried above.

PATIENT NAME: _____ **DATE:** _____

SIGNATURE: _____

Orthodontics Agreement Services:

Welcome to CDI Dental Group, where you will be part of a family of oral health care professionals. When you come to all your appointments, you will receive the full benefits that orthodontic treatment can offer. Know that you can trust us, and your friends and family are always welcome. Appointments will be made Mondays through Friday from 8:30 am to 5:00 pm and Saturdays from 8:30 am to 2:30 pm.

Item 1 – Type of Braces:

Down payment will include installation of braces, x-rays and photos. Unless under promotion.

A: **Aligners (Sure Smile)**: Down payment **$1500.00**, monthly maintenance varies from patient to patient, depending on the length of treatment.

B. **Regular Metal Braces:** Down payment **$499.00**, monthly maintenance of **$100.00**. (Cost of bracket repair **$20**)

C: **Regular Porcelain (clear) Braces:** Down Payment **$599.00**. Monthly maintenance of **$120.00**. (Cost of Bracket repair **$25.00**)

C: **Self-Ligation Metal Braces:** Down payment $**1,300.00**. Monthly maintenance of **$140.00**. (Cost of Bracket repair **$35.00**)

D: **Self-Ligation Porcelain (clear) Braces:** Down payment is **$1,600.00**. Monthly maintenance **$170.00**. (Cost of Bracket repair **$45.00**)

*During the **First 24 hours** of installation we will provide a **FREE RE-BOND** of any loose bracket if necessary. However, if it comes off and you're unable to come on the same day you must give us a call to let us know your bracket comes loose. We will note your file and you will NOT be charge at your next visit.

Item 2 – Missed/Cancelled Appointments:

A charge of **$95.00** will incur and will be added to your monthly payment for missing or canceling your confirmed appointments. We advise you to reschedule your appointment within **48 hours' notice**. If a patient misses their appointment for **3(+) consecutive months** a reactivation fee and a panoramic x-ray fee will be added to your monthly payment.

Item 3 – Not included with orthodontic treatment:

The cost that in these items refer exclusively to the orthodontic procedures. The need for restorative or surgical treatment will be an extra cost. Impairments caused in the braces due to incorrect use and bad hygiene will increase the chances of decay and another oral disease that will have to be treated and will cost more to treat. We advise you to get a cleaning every 4-6 months.

Item 4 – Appointment:

The teeth will not align properly if you miss appointments. Patients must follow the instructions of care as well attending to follow up appointments preferably 3-5 weeks after the last appointment. This is the patient's responsibility.

Item 5– Removing Brace Before Treatment:

There is no cancellation fee for treatment but if you like to remove the braces before treatment is completed and without authorization of the dentist, be advised that your teeth will move back to their original position and that will be your responsibility. There will be a charge of $150.00 for the removal of each arch. (Note: retainers are not included)

Item 6– Retainers:

For retainer's placement (after completing ortho treatment) there will be a charge of $350.00 for Hawley Retainer (Removable) or $400.00 for Fixed Bonded Retainer (Permanent). Please, be advised patients will have to come for follow up visits for the first 6 months after the removal of braces, please note that retainer checks cost $90.00 per visit.

Item 7 – Refer:

If you refer us to your friends and family, you will earn ONE FREE monthly maintenance for each friend/family that start treatment at CDI Dental Group.

Item 8– Panoramic X-rays & additional X-rays:

A panoramic x-ray is taken every 4-6 months for treatment purposes only. Cost of panoramic x-ray $70.00. If the doctor needs to see a root rotating of a tooth individual x-ray fee $15.00.

Item 9 – Already have Braces:

If you already have braces from another office treatment can be continued, you will have to pay the down payment.

Item 10– How treatment start:

The treatment will always start with bonding the upper arch or lower arch depending on the case, never both at once. We recommend for faster treatment, that the patient comes back in 3-4 weeks for regular treatment. Every follows up visit must be paid at the time of service.

Item 11– Color of Bands:

In case the patient does not like the color of the rubber bands places the day of installation they will NO charged to replace them, however, if it's been more than a day after installation there will be a $20.00 charge.

Item 12– Fee Increase:

We reserve the right to price increase at any time, the patient will get 30 -days' notice.

Item 13– Don't want to start treatment:

If you decide not to start the treatment after an x-ray has been taken, there will be a fee of $100.00 each.

Treatment and arbitration agreement:

Regarding dental care and service provided at CDI Dental Group, it is agreed that attending dentist will provide dental care services to the patient, to their skills and knowledge in which dental care is the light of circumstances is possible and practical. It is agreed that because of differences in the human constitution and response, it is no way possible to warrant the outcome of any dental or medical services. It is understood that any dispute as to dental malpractice that any dental service 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, not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceeding. Both patients to this contract by entering 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. Within fifteen days after a patient or attending dentist shall give notice to the other to demanding arbitration of such controversy, the patients to controversy shall each appoint a dentist as a neutral arbitrator and give notice to the selection thereof the parties. The arbitration shall hold a hearing with a reasonable time. All notice or other documents required to be served by United Stated 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 YOU ARE AGREEING TO HAVE ANY ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TO COURT TRIAL.

I authorize for CDI Dental Group to Communicate with me through text message, and I am donating my pictures and videos.

Patient Name: _____

Patient/Guardian Signature: _____ **Date:** _____

INFORMED CONSENT LIMITATION AND SIRK OF TREATMENT (ORTHODONTIC)

The following information is routinely provided to anyone considering orthodontic treatment in our office. While recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that orthodontic treatment, like any treatment of the body, has inherent risks and limitations. These are seldom enough to rule out treatment but should be considered when deciding to wear braces. Please note it is impossible to list every possible circumstance so this needs to be considered an incomplete list. Please read this content care and ask your dentist to explain anything you do not understand. A certain amount of discomfort should be expected when braces are put on and at each wire change.

ROOT RESORTION: in a very few cases, the ends of the roots of the teeth are shortened during treatment. In the event of subsequent gum disease, this root and resorption could reduce the longevity of affected teeth. Under healthy circumstances, the shortened tooth root is no disadvantage. It is nearly impossible to predict susceptibility to this condition. **Initial:** _____

RETURN OF ORIGINAL PROBLEM: Many problems tend to return by a fact of 10% or so. Especially very severe problems may do so. We will make our correction to the highest standard and hold the result carefully. When the retention is discontinued, we will except some return. Careful cooperation during the retention period will keep the rebound to a minimum. **Initial:** _____

DECALCIFICATION, DECAY OR MOST GUM DISEASE: problems may occur if the patient does not cooperate with brushing or flossing and regular checkups with the general dentist. Also essential is proper dietary control, pay special attention to the amount of sugar in your diet. With adult patients, we ask for increased attention to prevent gum diseases. If periodontal diseases occur during treatment it may be difficult or impossible to control the bone loss of the teeth. **Initial:** _____

ORTHODONTIC SURGERGAL CASES (ORTHOGNATHIC): As this is not exact and may complex factors influence the treatment; it is possible in certain individual cases that orthodontic treatment and surgery (Jaw modification surgery) is requested any phases during treatment. It is understood that you have the choice to discontinue, (de-band) or be referred to another dentist to treatment the surgical phase of the case. **Initial:** _____

TREATMENT PROGRESS: Can be delayed beyond our forest. Lacking facial growth, gum disease, poor headgear cooperation, broken application, and missed appointment are all important factions. **Initial:** _____

ADDICTION TREATMENT: Unforeseen circumstances (growth charges, gum disease) may cause us to recommend a form of treatment not previously discussed. If this occurs, we will carefully explain the reason for a change in the treatment plan and any extra fee proceeding. **Initial:** _____

LATE GROWTH CHANGES: Can upset the most careful treatment plan, a person who has grown in an average proportion may not continue to do so. If growth becomes disproportionate, the jaw relationship can be seriously affected, and original treatment objectives may not be met. **Initial:** _____

TMJ PAIN: some patients are very sensitive to even a slight discrepancy in their bite. The patient may suffer from noise pain in the joint or the lower jaw (near the ear). This may occur during or after orthodontic treatment. It also happens inpatient who never had orthodontic treatment. Let us know if you suspect a problem/pain so we can help before it gets worse. An imperfect bite may also cause TMJ problems. Orthodontic therapy alone cannot result in an absolutely perfect bite because of the complex factor influencing the alignment of your teeth. **Initial:** _____

DEVATALIZATION: it is possible for a tooth to die during orthodontic treatment, especially if it was previously injured or was impacted. Sometimes such injuries unknown to the patient or parents. Such precious injuries cannot be detected by the orthodontist. For that reason, a tooth may die and the reason for it may not be apparent. Root canals treatment may be recommended if you have such a problem. Extraction is usually not necessary. **Initial:** _____

INJURY FROM APPLICATION: Headgear instruction must carefully be followed. If headgear that is pulled away from the teeth while the elastic is attached could snap back into the face or eyes. Be sure to release the elastic force before removing the headgear from teeth, on a rare occasion when dental instruments are used in the mouth, the patient may get scratched, poked of receiving a blow to a tooth with potential or soreness to the oral structure. Brackets and wire can be dislodged or broken, I can appear to be swallowed or inhaled. The risk is increased when the patient advice and recommendations. Elastics and ligatures that are loosed should be pushed back into place with a pair of tweezers or a bent spoon. **Initial:** _____

REMOVAL OF TEETH: sometimes teeth must be extracted as part of orthodontic treatment. This will be based on the dentist's judgment of the case. Such removal can include but not limited to third molar teeth (wisdom teeth) and will not be done by the dentist but an Oral Surgeon or General Dentist as deemed necessary, and it's NOT included in the ortho treatment fee. **Initial:** _____

SUCCESS OF TREATMENT: We intended to do everything possible to provide the best result in every case and it is an opinion that the treatment will be beneficial. However, we cannot guarantee that the proposed treatment will be successful or to your complete satisfaction. Due to individual patient differences, there exists a possibility of failure, relapse, or selective retreatment, despite the best case. Much of the success of the treatment depends on the understanding and cooperation of the patient. **Initial:** _____

CARAMIS/METAL BRACKETS: There have been some reported incidents of patients experiencing brackets breakage and/or damage to the tooth. If brackets fracture outside of the office, it may result in sharp edges that be harmful to the patient. Also, these brackets may cause enamel flaking or enamel fracturing on the understanding and cooperation of the patient. **Initial:** _____

ACQUAINTANCES: We recommend that acquaintance waits at the reception area. Inside the work area in the clinic, there are harmful equipment and materials. We will not be responsible for any accident. **Initial:** _____

PAYMENT POLICIES: We have set up a payment schedule for your convenience. Please keep in mind that your monthly fee must be paid at the day of service. **Initial:** _____

INFORMED CONSENT AND TREATMENT AUTHORIZATION: I have read and understood the above item and have read the opportunity to discuss it with the dentist to clarify any areas it was not clear to the patient/guardian. I authorize CDI Dental Group to provide me an orthodontic treatment. The prescribed treatment was explained to me. **Initial:** _____

I further understand that, like other healing art, the practice of orthodontics is not exact science: therefore, results cannot be guaranteed and though every effort will be made to complete the treatment with the same dentist, who cannot guarantee that, I have been provided with a copy of this information consent.

Health History:

PLEASE CHECK ANY CONDITION THAT YOU CURRENTLY OR PREVIOUSLY SUFFER FROM:

__Aids/HIV __Alcoholism __Allergies __Anemia __Anorexia __Appendicitis __Arthritis __Asthma __Bleeding __Bronchitis __Bulimia __Cancer __Cataracts __Chicken Pox __Diabetes __Emphysema __Epilepsy __Fractures __Glaucoma __Heart Disease __High Blood Pressure __Heart Valve/Murmur __Hepatitis __Herpes __High Cholesterol __Lupus __Low Blood Pressure __MS __Mumps __Nervous Disorders __Neck/Back Problems __Pacemaker __Parkinson's __Polio __Psychiatric Care __Respiratory Problems __Rheumatoid Arth __Rheumatoid Fever __Seizures/Fainting Spells __Sinus Problems __Stomach Ulcers __Stroke __Thyroid Problems __Tonsillitis __Tuberculosis tumors/Growths __Ulcers __Venereal Disease __Viral infections Whooping Cough __Flu __Colds __Fibromyalgia __Migraines __Other: _____

MEDICAL QUESTION:

List any medications you are taking including nonprescription drug:

_____

_____

Are you allergic to any Medication? ___Yes ___No (If YES, please list below):

_____

_____

Are you in good health? ___ Yes ___ NO

Date of last Medical exam: _____

Have you ever been hospitalized? ___ Yes ___ No (If YES, what was the problem):

_____

_____

Have You any surgeries? ___ Yes ___ No (If YES, please explain):

_____

FOR WOMEN ONLY:

Are you taking birth control? __ Yes __ No
Are you nursing/breastfeeding? __ Yes __No
Are you pregnant? __ Yes __ No (**Due date**: _____)
Possibility of being pregnant? __ Yes __No

Dental History:

PLEASE CHECK ANY CONDITION THAT YOU CURRENTLY OR PREVIOUSLY SUFFER FROM:

__ Bleeding Gums __Broken Fillings __Chronic Bad Breath __Decayed Teeth __Food catches between teeth __Grinding teeth __Injury to teeth or jaw __Loose Teeth __Periodontal Treatment __Extractions __Sensitivity to hot, cold, sweet or pressure __Sores/swelling in mouth __TMJ

DENTAL QUESTION:

Date of last dental exam: _____
Name of previous dentist: _____
Reason of last visit: _____
Dental needs: _____
Name of general dentist office: _____
Phone number: _____
Do you have dental insurance? _____
How often do you floss? _____
Do gums bleed when you brush? Yes ___ No ___
Have you had any complication from an extraction? Yes ___ No ___ (If Yes, Explain)
_____
Have you ever had Orthodontic treatment? Yes ___ No ___
If Yes, how long ago? _____
Have you ever had an allergic reaction to crown, metal filling, or dental application? Yes__ No__

On a scale from 1 to 10 (with 10 being the highest) how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be?

__Whitening __Crowding/Crooked teeth __Jaw joint pain __Spaces __Missing teeth __Tooth shape __Dark teeth __Tooth size __Speech problems __Gummy smile __Overbite __Underbite __Facial profile Teeth are different colors __Ugly old crowns __Other: _____

Patient Signature: _____ **Date:** _____

HIPPA CONSENT FORM

I, _____ understand that under the Health Insurance Portability Act of 1996(HIPPA), I have a certain right to privacy regarding my protected health information (PHI), I understand that this information can and will be used to:

Conduct plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessment and physician's certifications.

You have informed me of your notice of Privacy Practices, which contains a more complete description of the uses and disclosers of my health information. I have given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization at any time at the address above to obtain a current copy of the notice of privacy practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restriction, but if you do agree to them you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent.

Patient's name: _____

Signature: _____ **Date:** _____

Relationship to Patient: _____

FINANCIAL AGREEMENT

Our goal is to provide the highest quality of dental care possible and have clear communication of our financial policy.

ALL ACCOUNTS/PAYMENT ARE DUE AT THE TIME OF SERVICE. If a procedure requires multiple appointments, payments are required in full at the first appointment.

PAYMENT OPTION:

1. **Cash**
2. **MasterCard**
3. **Visa**
4. **Novus/Discover**
5. **Apple Pay**

PATIENT WITH INSURANCE: the PATIENT is responsible for the ESTIMATED non-covered portion, procedures and/or deductibles at the time of service, OR the patient can sign a credit card authorization form to bill their credit card AFTER insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the full balance.

PARENTS NOT ACCOMPANYING THEIR CHILD to the appointment must make PRIOR arrangements for payment (Cash, Credit Card authorization or call in payment at (562)317-5258)

Parents accompanying their children are financially responsible for payment 18% of annual interest is charged for any unpaid balance. A $15 fee is charged for nonpayment. There is a $30.00 processing charge for non-sufficient funds.

RECORDS: can be viewed at any time. There is a nominal charge for release or copies of records.

I _____, agree to these financial terms.

Signature: _____ **Date:** _____

PHOTOGRAPHY RELEASE

I Hereby authorize CDI Dental Group, to publish photographs/videos taken of me during dental office visit, and my name in likeness, for use in the CDI Dental Group print, online and video-based marketing materials, as well as other office publications.

I the patient/guardian release and hold harmless CDI Dental Group from any reasonable expectation of privacy or confidentiality associated with that images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other dental office publications, I acknowledge and agree that publication of photographs confers no rights of ownership or royalties.

I hereby release CDI Dental Group, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me (the patient) any third party in connection with my participation.

Print Name: _____

Patient/Guardian Signature: _____

Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____