

BAYWOOD DENTAL GROUP
New Patient Information Form

Patient _____ Parent Name (if minor) _____ Birth date _____
Mr. Mrs. M.s Miss
Address _____ City _____ State _____ Zip _____
Patient or Parent employed by _____ Occupation _____
Business Address _____ City _____ State _____ Zip _____
Social Security # _____ Driver License/ID# _____

How may we reach you?

Please list your contact numbers and the hours you can be reached at that number

Phone: home#: _____ hours _____ cell# _____ hours _____ Work# _____ x _____ hours _____
Additional contact sources: Email address _____ pager _____ Fax _____

Reason for your visit today _____ How did you hear about this office? _____
Please list any family members that are patients of this practice _____
Person to contact in case of emergency _____ phone _____

Insurance/Dental Plan Information

Insured Persons' Full Name _____ Relationship to patient _____
Date of birth _____ SS# _____ Insurance/plan Name _____
Employer's name _____ Address _____ Phone _____
(if different then above)

Assignment of Insurance Benefits

I hereby authorize **Alireza Movassaghi, D.D.S.** and/or Baywood Dental Group to furnish information to insurance carriers concerning treatment and hereby assign to the doctors all payment for dental services rendered. This assignment will remain in effect until revoked by me in writing, a photocopy of this assignment is as valid as original. **I understand that I am Financially responsible for all charges whether or not paid by said Insurance/Dental Plan.** I hereby authorize said assignee to release all information necessary to secure payment.

Signature _____ Date _____ Witness _____

Treatment and Arbitration Agreement

With regard to dental care and services provided or to be provided at Baywood Dental Group, it is agreed that the attending dentists will provide dental care and services to the patient, to the best of their skills and knowledge which dental care in the light of circumstances is possible and practical. It is agreed that because of differences in human constitution and response, it is in no way possible to warrant the outcome of any medical or dental service.

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 unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Within fifteen days after a Patient or Attending Dentist shall give notice to the other demanding arbitration of such controversy, the parties to the controversy shall each appoint a licensed dentist as arbitrator and give notice of such appointment to the other. Within a reasonable time the two arbitrators shall select a licensed dentist as neutral arbitrator and give notice to the selection there of to the parties. The arbitrators shall hold a hearing within a reasonable time. All notices or other papers required to 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 ISSUE OF DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Date _____ Signature of patient (or parent/guardian) _____ Relationship _____

Date _____ Signature of attending dentist _____ Witness _____