Spark Family Dental
IGNITE YOUR SMILE

Patient Information Sheet

DATE	
CHART #	

PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	DOB	SEX M ☐ F ☐

SSN	ID TYPE (SELECT ONE) ☐ DRIVER'S LICENSE ☐ STATE ID ☐ FEDERAL ID ☐ PASSPORT ☐ OTHER	DRIVER'S LICENSE/ID #	ST

E-MAIL	HOME PHONE	CELL PHONE	WORK PHONE	PREFERRED LANGUAGE	DECLINED TO SPECIFY ☐

HOME ADDRESS	APT	CITY	ST	ZIP

EMPLOYER	POSITION	HOW LONG? YEAR MONTH

EMPLOYER ADDRESS	CITY	ST	ZIP

RESPONSIBLE PARTY (DISREGARD IF SAME AS ABOVE)

FIRST NAME	MI	LAST NAME	DOB	SEX M ☐ F ☐	RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ OTHER ☐ PARENT

SSN	ID TYPE (SELECT ONE) ☐ DRIVER'S LICENSE ☐ STATE ID ☐ FEDERAL ID ☐ PASSPORT ☐ OTHER	DRIVER'S LICENSE/ID #	ST

E-MAIL	HOME PHONE	CELL PHONE	WORK PHONE	PREFERRED LANGUAGE	DECLINED TO SPECIFY ☐

HOME ADDRESS	APT	CITY	ST	ZIP

EMPLOYER	POSITION	HOW LONG? YEAR MONTH

EMPLOYER ADDRESS	CITY	ST	ZIP

MEDICAL CONTACTS: CURRENT DENTIST

DENTIST NAME	PHONE NUMBER

ADDRESS	CITY	ST	ZIP

EMERGENCY CONTACTS

CONTACT #1 FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	

E-MAIL	HOME PHONE	CELL	WORK PHONE

CONTACT #2 FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	

E-MAIL	HOME PHONE	CELL	WORK PHONE

PRIMARY INSURANCE

☐ INSURANCE CARD PROVIDED

INSURED'S FIRST NAME	LAST NAME	

DOB	SEX M ☐ F ☐	INSURED'S RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ OTHER ☐ PARENT

HOME ADDRESS	APT

CITY	ST	ZIP	INSURED'S SSN

EMPLOYER	EMPLOYER'S PHONE NUMBER

INSURANCE COMPANY	INSURANCE COMPANY'S PHONE NUMBER

GROUP #	POLICY #

POLICY EFFECTIVE DATE	UNION NAME AND LOCAL UNION NUMBER

SECONDARY INSURANCE

☐ INSURANCE CARD PROVIDED

INSURED'S FIRST NAME	LAST NAME	

DOB	SEX M ☐ F ☐	INSURED'S RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ OTHER ☐ PARENT

HOME ADDRESS	APT

CITY	ST	ZIP	INSURED'S SSN

EMPLOYER	EMPLOYER'S PHONE NUMBER

INSURANCE COMPANY	INSURANCE COMPANY'S PHONE NUMBER

GROUP #	POLICY #

POLICY EFFECTIVE DATE	UNION NAME AND LOCAL UNION NUMBER

INITIALS OF PATIENT	INITIALS OF RESPONSIBLE PARTY

Spark Family Dental
IGNITE YOUR SMILE

Patient Information Sheet

DATE
CHART #

_____ INITIALS **Financial Responsibility:** I understand that payments for services should be made when due, and if any payment is not made timely, I may be subject to late fees. I further understand that if I have authorized debits to my account and should my bank should honor a debit, I will incur a service charge for each such dishonored debit. I request that all benefits, if any, or other amounts otherwise payable to me or on my behalf for services rendered, be paid directly to the service provider. I understand that I am responsible for all charges for services, whether or not paid by insurance. I authorize the service provider to disclose all information necessary to verify my insurance eligibility and secure the payment of benefits.

_____ INITIALS **Information Verification:** The information provided herein is true and complete to the best of my knowledge. I authorize Spark Family Dental (SFD), or anyone acting on its behalf, to obtain, review and/or share with its designated agents, or any assignee of my account, my credit report for the purpose of evaluating my credit and verifying my identity, or for updating, renewing, servicing, modifying or collecting my account. This authorization is valid as long as any amounts are owed on my account to SFD or any assignee of my account. I acknowledge that SFD may report information about my account to consumer reporting agencies and other persons who may legally receive such information. Late payments, missed payments or other defaults on my account may be reflected in my credit report.

_____ INITIALS **Prior Express Consent for Calls/Texts/Email:** By providing the number of my land line, cell phone or other wireless device and my email address now or in the future, I expressly consent and agree that SFD and any of its affiliates, agents, service providers or assignees may call me using an automatic telephone dialing system or otherwise, leave me a voice, prerecorded, or artificial voice message, or send me text, e-mail, or other electronic message for any purpose related to the servicing or collection of any account that I may establish with SFD, or for other informational purposes related to my account or treatment ("Communication"). I also agree that SFD and any of its affiliates, agents, service providers or assignees may include my personal information in a Communication. SFD will not charge for a Communication, but my service provider may. I agree that SFD may monitor and record any telephone calls to assure the quality of its service or for other reasons.

_____ INITIALS **Broken Appointment Fee:** I understand that it is important to keep my scheduled appointments, and if I miss an appointment without prior notification, I may be subject to a broken appointment fee.

Madhavi Suersh Seri DDS Inc. ("MSS") will use electronic medical records, including your photograph, to maintain your health care information. MSS is committed to maintaining the privacy and confidentiality of patient health information in compliance with HIPAA, and will only use your photograph for internal identification purposes.

You may withdraw this consent with written notice to MMS at any time.

_____ INITIALS **Yes.** I agree to have my photograph taken and stored in MSS's electronic medical records system. I understand that by checking "Yes" and signing below, I am giving MSS permission to take and use my photograph in its electronic medical records system for identification purposes.

_____ INITIALS **No.** I do not wish to have my photograph taken and stored in MSS's electronic medical records system.

By signing below, I acknowledge that I have read, fully understand, and agree to be bound by this consent.

_____ SIGNATURE OF PATIENT

_____ DATE

_____ SIGNATURE OF RESPONSIBLE PARTY

_____ RELATIONSHIP TO PATIENT

_____ DATE

HEALTH HISTORY

Patient First Name | MI | Last Name | Birthdate | Sex ☐Male ☐Female

GENERAL HEALTH QUESTIONS

1. Have you had any serious illness, operations or hospitalizations? ☐Yes ☐No

2. Are you under a physician's care at this time? ☐Yes ☐No

Name, address and phone # of physician:

Do you have or did you ever have any of the following?

Cardiovascular Health

3. High blood pressure ☐Yes ☐No
4. Angina or heart attack ☐Yes ☐No
5. Chest pain on physical exertion ☐Yes ☐No
6. Coronary artery blockage or treatment (bypass, stent, etc.) ☐Yes ☐No
7. Heart valve problem or replacement ☐Yes ☐No
8. Heart murmur ☐Yes ☐No
9. Heart disease, problem or treatment ☐Yes ☐No
10. Rheumatic fever ☐Yes ☐No
11. Past use of Fen-Phen ☐Yes ☐No
12. Irregular heart beat or pacemaker ☐Yes ☐No
13. Difficulty breathing when lying down ☐Yes ☐No
14. Stroke ☐Yes ☐No
15. Low blood pressure ☐Yes ☐No

Respiratory Health

16. Asthma ☐Yes ☐No
17. Emphysema or respiratory problems ☐Yes ☐No
18. Chronic sinus problems ☐Yes ☐No
19. Tuberculosis or persistent cough ☐Yes ☐No

Endocrine/Blood/Immune Health

20. Diabetes ☐Yes ☐No
21. Frequent thirst or frequent urination ☐Yes ☐No
22. Thyroid problems ☐Yes ☐No
23. Abnormal bleeding, bruise easily ☐Yes ☐No
24. Hemophilia ☐Yes ☐No
25. Anemia/blood disease ☐Yes ☐No
26. Cancer ☐Yes ☐No
27. Radiation therapy/chemotherapy ☐Yes ☐No
28. HIV infection/AIDS ☐Yes ☐No
29. Cold sores/canker sores ☐Yes ☐No
30. Organ transplant ☐Yes ☐No
31. Blood transfusion ☐Yes ☐No

Muscular-Skeletal/CNS/Mental Health

32. Joint replacement ☐Yes ☐No
33. Arthtritis ☐Yes ☐No
34. Osteoporosis ☐Yes ☐No
35. Fainting spells or dizziness ☐Yes ☐No
36. Seizures ☐Yes ☐No
37. Numbness or muscle weakness ☐Yes ☐No
38. Multiple sclerosis ☐Yes ☐No
39. Intellectual Disability ☐Yes ☐No
40. Dementia/Alzheimer's disease ☐Yes ☐No
41. Anxiety/Nervousness ☐Yes ☐No
42. Mental health treatment ☐Yes ☐No

Gastro-Intestinal/Genito-Urinary Health

43. Hepatitis (A, B, C or other) ☐Yes ☐No
44. Liver disease ☐Yes ☐No
45. Kidney disease/dialysis ☐Yes ☐No
46. Stomach trouble/ulcers ☐Yes ☐No
47. Sexually transmitted disease ☐Yes ☐No

Medication Allergies and Other Allergies

48. Penicillin or other antibiotics ☐Yes ☐No
49. Sulfa drugs ☐Yes ☐No
50. Dental antesthetic ☐Yes ☐No
51. Aspirin ☐Yes ☐No
52. Codeine/narcotics ☐Yes ☐No
53. Iodine ☐Yes ☐No
54. Latex products ☐Yes ☐No
55. Metals/nickels/jewelry ☐Yes ☐No
56. Other: _____

Females Only

57. Are you pregnant? ☐Yes ☐No
58. Are you nursing now? ☐Yes ☐No
59. Do you take birth control pills? ☐Yes ☐No

Medications

60. Are you taking any prescription medications, over the counter medications or herbal medicines? ☐Yes ☐No

If so, please list them and the dose taken:

_____

61. Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? ☐Yes ☐No

Social

62. Do you use tobacco? ☐ Yes ☐ No Quantity _____ Per Day
63. Do you use alcohol? ☐ Yes ☐ No Quantity ☐Per Day ☐Per week
64. Do you use recreational drugs? ☐ Yes ☐ No Quantity Per Day
65. Do you have any other medical conditions not already listed above? ☐Yes ☐No

Please list:

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the unsigned, consent to the performing of x-rays and examination.

Signature of PATIENT or GUARDIAN _____ Date _____

Signature of DENTIST _____ ID# _____ Date _____

UPDATE Have there been any changes in your medical history, including any medications you take, since your last completed form? ☐Yes ☐No

Signature of PATIENT or GUARDIAN _____ Date _____

Signature of DENTIST _____ Date _____

Madhavi Suresh Seri DDS Inc.

ARBITRATION AGREEMENT

WAIVER OF RIGHT TO JURY TRIAL

Patient Name:_____ **Chat No:**_____ **Office Loc:**___

Article 1: Agreement to Arbitrate Medical Malpractice and Other Disputes: It is understood that any dispute as to medical malpractice, whether any medical services rendered under this contract were unnecessary or unauthorized, or 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 dispute decided in a court of law before a jury, and instead accept arbitration.

It is further understood that any dispute related to or arising from charges, billings, payments, financing, debt collection, solicitations and/or marketing relating to any medical or dental services offered by or rendered by Madhavi Suresh Seri DDS Inc (MSS) will be determined by submission to arbitration as provided pursuant to the terms outlined herein.

Article 2: All Claims Must Be Arbitrated: It is the intention and agreement of the parties that this arbitration agreement shall cover all claims or controversies relating to the matter described in Article 1 above, except claims within the jurisdiction of the Small Claims Court, whether the tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress, or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described in Article 1 may arise out of or in any way related to treatment or services provided or not provided by Madhavi Suresh Seri DDS Inc ("MSS") or any employee or agent or provider of MSS, including any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. The undersigned understands and agrees that if the undersigned signs this Contract on behalf of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person.
The reference to MSS includes the corporation, and its employees, agents and providers.

Article 3: Class Action Waiver: It is the intention and agreement of the parties that any arbitration brought pursuant to this agreement shall be conducted on an individual basis only, and not on a class, collective or representative basis. There will be no right or authority for any dispute to be brought, heard or arbitrated as a class, collective, or representative action, or as a member in any purported class, collective, representative proceeding ("Class Action Waiver"). Disputes regarding the validity and enforceability of the Class Action Waiver may be resolved only by a civil court of competent jurisdiction and not by an arbitrator. In any case in which (1) the dispute is filed as a class, collective, or representative action and (2) a civil court of competent jurisdiction finds all or part of the Class Action Waiver unenforceable, the class, collective, and/or representative action to that extent must be litigated in a civil court of competent jurisdiction, but the portion of the Class Action Waiver that is enforceable shall be enforced in arbitration.

Article 4: Procedures and Applicable Law: Patient shall initiate arbitration by serving a Demand for Arbitration on MSS and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: Spark Family Dental, 1940 N Tracy Blvd, Tracy, CA 95376. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient and his/her attorney. Patient and MSS agree that any arbitration here under shall be conducted by a single, neutral arbitrator selected by the parties and shall be resolved using the rules of American Arbitration Association then in effect at the time the requirements are met for a demand for arbitration (located at https://adr.org/). (Arbitration, however, shall not be conducted by the American Arbitration Association and shall be conducted by an arbitration agency mutually selected by the parties). Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Civil Code 333.1 and 3333.2, Code of Civil Procedure 340.t, 667.7, 1281-1295 and the Federal Arbitration Act (9 U.S.C 1-9), as in effect from time to time. The parties shall bear their own costs, fees, and expenses along with a pro-rata share of the arbitrator's fees and expenses.

Article 5: Retroactive Effect: Patient intends this Contract to cover services rendered by MSS not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 6: Severability: If any provision of this Contract is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that this Contract is voluntary and that if I do sign it, I may rescind it only by giving written notice which must be delivered to and received by MSS at the address outlined in Article 4 within 30 days of signature.

I understand that I have the right to receive a copy of this Contract, By my signature below, I acknowledge that I have read and understand the Contract, agree to its terms and have received a copy.

NOTICE: BY SIGNING THE CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE AND ANY ISSUES OUTLINED IN ARTICLE 1 DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____ Date Signed:_____

Print Patient's Name (Signature of Patient, Parent, Guardian or Legally Authorized Representative of Patient)

MADHAVI SURESH SERI DDS INC'S AGREEMENT TO ARBITRATE
In consideration of the foregoing agreements under this Contract, MSS likewise agrees to be bound by the terms set forth in this Contract and to the rules specified in Article 4 above.

_____ _____ Date Signed:_____

Prepared by MSS employee Print Name

A signed copy of this document is to be given to the Patient. The Original is to be filed in the Patient's dental chart.

Spark Family Dental
IGNITE YOUR SMILE

Acknowledgement of Receipt of:
Dental Materials Fact Sheet &
Spark Family Dental's Notice of Privacy Practice

By signing this document, I acknowledge that I have received a copy of

☐ Dental Materials Fact Sheet

☐ Spark Family Dental's Notice of Privacy Practice

NAME (PRINT)	SIGNATURE	DATE