PLEASE FILL OUT THIS FORM AND CLICK SUBMIT

Chart No. _____ Office _____ Date _____

A) Patient
Name (Nombre) _____

Age (Edad)_____Weight (Peso) _____
Birthdate
Fecha de Nacimiento)_____

Address (Direccion) _____Apt. No. _____

City (Ciudad)_____Zip Code (Zona) _____ Phone (Telefono) _____
Driver's License # Social Security Number
(Numero de Licencia) _____(Numero de Seguro Social)_____

Occupation (Ocupacion)_____ Employed by (Empleado por) _____ .

How Long (Por Cuanto Tiempo) _____ Business Phone (Telefono de su Trabajo) _____

Business Address (Direccion de su Trabajo)_____

B) Responsible Party or Spouse (Persona Responsible 6 Esposo(a)_____

Address (Direccion) _____Apt. No. _____City (Ciudad)_____

Zip Code (Zona) _____Responsible Party Phone (Telefono de Persona Responsible) _____

Driver's License # Social Security Number

(Numero de Licencia) _____(Numero de Seguro Social)_____ „ _____

Occupation (Ocupacion)_____ Employed by (Empleado por)_____

How Long (Por Cuanto Tiempo) _____ Business Phone (Telefono de su Trabajo) _____

Business Address (Direccion de su Trabajo)_____

C) In Case of Emergency Contact Name Phone
(En Caso de Emergencia Llame a (Nombre))_____ (Telefono) _____

D) Referred by_____

INSTRUCTIONS	YES-SI	NO	INSTRUCCIONES
ANSWER ALL QUESTIONS AND FILL IN BLANK SPACES WHEN INDICATED ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE CONFIDENTIAL			CONTESTE TODAS LAS PREGUNTAS Y LLENE LOS ESPACIOS EN BLANCO CUANDO SE INDIQUE LAS CONTESTACIONES A NUESTRAS PREGUNTAS SON UNICAMENTE PARA NUESTROS ARCHIVOS Y SE CONSIDERAN ESTAS EXTRICTAMENTE CONFIDENCIALES.:
1. HAVE YOU HAD FOOD OR DRINK TODAY	_____	_____	1. HA COMIDO 6 BEBIDO ALGO EL DIA DE HOY
2. ARE YOU IN GOOD HEALTH.....	_____	_____	2. ESTA USTED EN BUENA SALUD
A. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	_____	_____;	A. HA HABIDO CAMBIO EN SU SALUD EN EL ANO PASADO
3. MY LAST PHYSICAL WAS ON _____ _ _			3. MI ULTIMO EXAMEN MEDICO FUE EN _____
4. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	_____	_____	4. ESTA AHORA BAJO ATENCION MEDICA
A. IF SO WHAT IS THE CONDITION BEING TREATED _____			A. SI ES ASI, QUE ENFERMEDAD SE ESTA CURANDO_ _____

INSTRUCTIONS	YES-SI	NO	INSTRUCCIONES
5. THE NAME AND ADDRESS OF MY PHYSICIAN IS _____			5. EL NOMBRE Y DOMICILIO DE MI MEDICO ES _____
6. HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION.....	_____	_____	6. HA TENIDO ALGUNA ENFERMEDAD SERIA U OPERACION
7. HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS.....	_____	_____	7. DURANTE LOS ULTIMOS CINCO(5)ANOS HA SIDO
ILLNESS WITHIN THE PAST 5 YEARS ..... '.....	_____	_____	HOSPITALIZADO O TENIDO UNA SERIA ENFERMEDAD
A. IF SO WHAT IS THE PROBLEM _____			A. SI CONTESTA AFIRMATIVAMENTE EXPLIQUE _____
8. DO YOU DRINK ALCOHOLIC BEVERAGES	_____	_____	8. USTED TOMA BEBIDAS ALCOLICAS
9. DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS			9. TIENE O HA TENIDO ALGUNA DE LAS SIGUIENTES ENFERMEDADES O PROBLEMAS
A. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE	_____	_____	A. FIEBRE REUMATICA O REUMA CARDIACA
B. CONGENITAL HEART LESIONS.....	_____	_____	B. LESION CARDICA CONGENITA
C. CARDIOVASCULAR DISEASE (HEART TROUBLE, HEART	_____	_____	C. ENFERMEDAD CARDIOVASCULAR (ENDERMEDAD DEL
ATTACK, CORONARY INSSUFFICIENCY, CORONARY	_____	_____	CORAZON, INSSUFICIENCIA CARDICA, OCLUSION
OCCLUSION, HIGH BLOOD PRESSURE, ...	_____	_____	CORONARIA, ALTA PRESION ARTERIAL,
ARTERIOSCLEROSIS, STROKE)	_____	_____	ASTERIOSCLEROSIS, SINCOPE)
1) DO YOU HAVE PAIN IN CHEST UPON EXERTION	_____	_____	1) TIENE ALGUN DOLOR EN EL PECHO CUANDO HACE ALGUN ESFUERZO
2) ARE YOU EVER SHORT OF BREATH AFTER MILD	_____	_____	2) DESPUES DE HACER ALGUN EJERCICIIO SIENTE
EXERCISE.....	_____	_____	FALTARLE EL AIRE
3) DO YOUR ANKLES SWELL	_____	_____	3) SE LE HINCHAN LOS TOBILLOS
4) DO YOU GET SHORT OF BREATH WHEN YOU LIE.....	_____	_____	4) CUANDO SE ACUESTA SIENTE QUE LE FALTA AIRE PARA
DOWN OR DO YOU REQUIRE EXTRA PILLOWS	_____	_____	RESPIRAR O LE FALTAN MAS ALMOHADAS CUANDO
WHEN YOU SLEEP	_____	_____	DUERME
D. ALLERGY	_____	_____	D. ALERGIA .
E. ASTHMA OR HAY FEVER.....	_____	_____	E. ASMA 6 FIEBRE DEHENO
F. HIVES OR SKIN RASH	_____	_____	F. RONCHAS 6 SARPULLIDO
G. FAINTING SPELLS OR SEIZURES.....	_____	_____	G. DESMAYOS Y SUDORES
H. DIABETES.....	_____	_____	H. DIABETIS
1) DO YOU HAVE TO URINATE (PASS WATER) MORE	_____	_____	1) ORINA USTED MAS DE SEIS VECES POR DIA
THAN 6 TIMES A DAY	_____	_____	
2) ARE YOU THIRSTY MUCH OF THE TIME.....	_____	_____	2) TIENE SED LA MAYORIA DEL TIEMPO
3) DOES YOUR MOUTH FREQUENTLY BECOME DRY	_____	_____	3) SE LE RESECA LA BOCA FRECUENTEMENTE
I. HEPATITIS, JAUNDICE OR LIVER DISEASE	_____	_____	I. MALESTAR BILIOSO, HAPATITIS O ENFERMEDAD RENAL
J. ARTHRITIS.....	_____	_____	J. ARTRITIS
K. INFLAMATORY RHEUMATISM (PAINFUL, SWOLLEN JOINTS)	_____	_____	K. INFLAMACION REUMATICA (COYONTURAS INFLAMADAS CON DOLOR)
L STOMACH ULCERS	_____	_____	L ULCERAS ESTOMACALES
M. KIDNEYTROUBLE	_____	_____	M. ENFERMEDAD DEL RINON
N. TUBERCULOSIS	_____	_____	N. TUBERCULOSIS
O. DO YOU HAVE A PERSISTENT COUGH OR COUGH UP BLOOD	_____	_____	O. TOS PERSISTENTE O TOSE SANGRE
P. LOW BLOOD PRESSURE.....	_____	_____	P. BAJA PRESION SANGUINEA
Q. VENEREAL DISEASE	_____	_____	Q. ENFERMEDADES VENEREAS
R. DO YOU SUFFER FROM ANY TYPE OF NERVOUS CONDITION.....	_____	_____	R. PADECE UD DE ALGUN TRASTORNO NERVIOSO
IF SO, WHAT?_____			SI ES ASI, DE QUE_____

INSTRUCTIONS	YES-SI	NO	INSTRUCCIONES
S. AIDS OR TEST HIV POSITIVE.....	_____	_____	S. SIDA 6 LA PRUEBA SIDA POSITIVA
T. OTHER _____			T. OTRAS ENFERMEDADES _____
10. HAVE YOU HAD ABDOMINAL BLEEDING ASSOCIATED WITH PREVIOUS EXTRACTIONS, SURGERY OR TRAUMA.....	_____	_____	10. HA SANGRADO ANORMALMENTE, CUANDO UNA EXTRACCION DENTAL, CIRUJIA O TRAUMA
A. DO YOU BRUISE EASILY.....	_____	_____	A. SEMORETASUPIELFACILMENTE
B. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION ..	_____	_____	B. HA REQUERIDO TRANSFUSION SANGUINEA
IF SO, EXPLAIN THE CIRCUMSTANCES _____			SI CONTESTA AFFIRMATIVAMENTE EXPLIQUE _____
11. DO YOU HAVE ANY BLOOD DISORDER SUCH AS ANEMIA	_____	_____	11. TIENE ALGUN DESORDEN SANGUINEO TAL COMO ANEMIA
12. HAVE YOU HAD SURGERY OR X-RAY TREATMENT FOR A TUMOR, GROWTH, OR OTHER CONDITION OF YOUR MOUTH OR LIPS.....	_____	_____	12. HE TENIDO CIRUJIA O RAYOS X PARA TRATAR ALGUN TUMOR, CRECIMIENTO U OTRA ENFERMEDAD BUCAL O LABIAL
13. ARE YOU TAKING ANY DRUG OR MEDICINE.....	_____	_____	13. ESTA TOMANDO ALGUNA DE LAS SIGUIENTES MEDICAMENTOS
IF SO, WHAT? _____			SI ES ASI, QUE ESTA TOMANDO_____
14. ARE YOU TAKING ANY OF THE FOLLOWING:			14. ESTA TOMANDO ALGUNA DE LAS SIGUIENTES MEDICAMENTOS:
A. ANTIBIOTICS OR SULFA DRUGS	_____	_____	A. SULFAS O ANTIBIOTICOS
B. ANTICOAGUANTS (BLOOD THINNERS).....	_____	_____	B. ANTICOAGULANTES (ADELGAZADOR SANGUINEO)
C. MEDICINE FOR HIGH BLOOD PRESSURE	_____	_____	C. MEDICAMENTO CONTRA LA ALTA PRESION
D. CORTISONE (STEROIDS)	_____	_____	D. CONTIZONA (ESTEROIDES)
E. TRANQUILIZERS	_____	_____	E. TRANQUILIZANTES
F. ASPIRIN	_____	_____	F. ASPIRINA
G. INSULIN, TOLBUTAMIDE (ORINASE) OR SIMILAR DRUG	_____	_____	G. INSULINA, TOBULATAMIDA (ORINASE) O DROGAS SIMILARES
H. DIGITALIS OR DRUGS FOR HEART TROUBLE.....	_____	_____	H. DIGITALES O MEDICAMENTOS PARA ENFERMEDADES CARDIACAS I.
I. NITROGLYCERIN.....	_____	_____	NITROGLICERINA J.
J. AMPHETAMINES (SPEED)	_____	_____	ANFETAMINA K.
K. COCAINE.....	_____	_____	COCAINA L.
L. HEROIN	_____	_____	HEROINA
M. BARBITURATES, SEDATIVES OR SLEEPING PILLS	_____	_____	M. BARBITURICOS, SEDANTES O PASTILUAS PARA DOMIR
N. N. METHADONE.....	_____	_____	N. METHADONE
O. OTHER _____	_____	_____	O. OTROS MEDICAMENTOS_____
15. ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSERLY TO:			15. ES USTED ALERGICO O REACCIONA ADVERSAMENTE A LOS SIGUIENTES TRATAMENTOS
A. LOCAL ANESTHETIC	_____	_____	A. ANESTISIA LOCAL
B. PENICILLIN OR OTHER ANTIBIOTICS	_____	_____	B. ANTIBIOTICOS O PENICILINA
C. SULFA DRUGS.....	_____	_____	C. DROGAS CON SULFAS
D. BARBITURATES, SEDATIVES OR SLEEPING PILLS.....	_____	_____	D. BARNITURICOS, SEDANTES O PASTILLAS PARA DORMIR
E. ASPIRIN	_____	_____	E. ASPIRINA
F. IODINE	_____	_____	F. YODO
G. LATEX	_____	_____	G. GUANTES DE PLASTICO, LATEX
H. OTHER _____			H. ALGUNA OTRA _____
16. HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT.....	_____	_____	16. HE TENIDO ALGUN PROBLEMA DESPUES DE HABER TENIDO UN TRATAMIENTO DENTAL
IF SO EXPLAIN_____			SI ES ASI EXPLIQUEME _____
17.ARE YOU TAKING “PHEN-FEN” OR REDUX	_____	_____	17.ESTA TOMANDO “PHEN-FEN” O REDUX

INSTRUCTIONS	YES-SI	NO	INSTRUCCIONES
17. DO YOU HAVE ANY DISEASE CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT..... IF SO PLEASE EXPLAIN_____	☐	☐	17. TIENE USTED ALGUNA ENFERMEDAD O CONDICION FISCA 0 AGUN PROBLEMA NO ENUMERADO ANTERIORMENTE Y QUE USTED CREA QUE YO DEBA SABER SI ES ASI EXPLIQUEME _____
18. ARE YOU PREGNANT.....	☐	☐	18. ESTA USTED ENCINTA(EMBARAZADA)
19. HAVE YOU BEEN PREGNANT IN THE LAST 6 MONTHS ...	☐	☐	19. HA ESTADO UN ENCINTA DURANTE LOS ULTIMOS 6 MESES

I have filled out this Health Questionnaire completely. I have advised you of all medical problems of which I am aware.

Signature of Patient Date

If minor, Signature of Parent or Guardian Date

He contestado este Cuestionario de Salud totalmente. He dado a conocer todos los trastornos de los que tengo conocimiento.

Firma de Paciente Fecha

Si Menor, Firme Padre o Guardian Fecha

This is to certify that I, the undersigned, consent to the performing of X-rays, examination and whatever dental treatment may be agreed upon to be necessary or advisable.

Signature of Patient Date

If minor, Signature of Parent or Guardian Date

Esto certifica que yo, el que firma, presto me concentimiento para que hagan el ulso de rayos X, examinacion o cualquier tratamiento dental que sea de acuerdo o aconsejado.

Firma del Paciente Fecha

Si Menor, Firme Padre o Guardian Fecha

DO NOT SIGN THE FOLLOWING UNTIL YOU HAVE DISCUSSED YOUR TREATMENT WITH THE DENTIST.

I hereby consent to the administration of anesthesia and the oral surgery deemed advisable by Dr._____ or a qualified member of his staff. I have been informed of all risks involved in oral surgery and anesthesia, including blood loss, infection and cardiac arrest. I will not drink or eat anything during the eight hours preceding my appointment. I will bring someone to drive or escort me home following surgery. I am aware that drowsiness is increased by the use of alcohol drugs, or other medications and the use of such before or after surgery is dangerous.

Signature of Patient Date

Signature of Doctor Date

NO FIRME LO QUE SIGUE AL MENOS QUE HA YA DISCUTIDO SU TRA TAMIENTO CON EL DENTIST A.

Por medio de la presente doy el concentimiento para que se me applique la anestecia y se haga la operacion bucal que considere necesaria al Dr. _____ o algun miembro capacitado de su personal. Se me ha informado de todos los riesgos relaciones a la circujia y la anestecia bucal, incluyendo lo que respecta a la perdida de sangre, a los infecciones y ataques cardiacos. Yo no tomare o comere nada desde ocho horas antes de mi cita. Yo traere a alguien para que al tomar bebidas alcolicas, drogas u otros medicamentos anumenta el mareo, y que el ingerir tales substancias antes o despues de la operacion es peligroso.

Firma del Paciente Fecha

Firma del Doctor Fecha

INFORMED CONSENT

PATIENT NAME _____ CHART NO _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings☐, Bridges☐, Crowns☐, Extractions☐, X-rays ☐, Impacted Teeth Removals☐, Root Canals☐, Dentures☐, Partials ☐, Periodontal TX☐, Other ☐, Examination ☐

2. DRUG AND MEDICATIONS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make those changes as necessary. Initials_____

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth #_____
and any others necessary under paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.

5. ANESTHESIA

I realize the risks involved in receiving a local anesthetic, some of which are: partial facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage; hemorrhage, nerve damage and/or numbness.

6. CROWNS, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered, and that if I don't have the permanent crown(s) placed permanent serious damage or loss of the tooth/teeth involved my ensue, and that if I delay placement I may cause the teeth involved to move so that the permanent crown no longer will fit properly

7. DENTURES — COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone change.

8. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily effect the success of the treatment, and that this treatment often requires multiple visits and that I can cause serious damage or loss of the tooth/teeth involved if I do not complete the prescribed treatment.

9. PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. (Initials)_____

I hereby request and authorize the Dentists, and their Staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, as explained above.
The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me.
I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.
I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues (Paresthesia), fractured jaw, etc., have been clearly explained to me.
I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature_____ Date:_____/_____/_____

Witness_____ Date:_____/_____/_____

Doctor_____ Date:_____/_____/_____

HIPAA NOTICE OF PRIVACY PRACTICES

HOVSEP NARGIZYAN, D.D.S.
1655 N. MOUNT VERNON AVE, UNIT B
SAN BERNARDINO, CA 92411
TEL: (909) 885-8707
FAX: (909) 885-9447

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made/if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. ***We will not retaliate against YOU for filing a complaint.***

This notice was published and becomes effective on/or before **April 14.2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date_____

CHART NO._____

DENTAL SERVICES AGREEMENT

_____("Doctor"), and the undersigned_____ ("Patient") have agreed as follows:

ARTICLE 1. IT IS UNDERSTOOD THAT ANY DISPUTE AS TO DENTAL MALPRACTICE. THAT IS AS TO WHETHER ANY DENTAL SERVICES 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 SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION.

ARTICLE 2. In the event of any claim, demand, controversy or dispute the essential nature of which involves personal injury malpractice or any tort, by Patient, his dependents, whether or not minors, heirs at law or personal representatives against Doctor or any of Doctor's officers, directors, shareholders, agents, representatives, employees, successors in interests, assigns or associates agreeing in writing to be bound by the arbitration provisions of this agreement ("Affiliates"). THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The parties hereby agree that they shall submit their controversy loan Arbitrator who is a dentist licensed in California. Such Arbitrator shall be acceptable to both parties. In the event that the parties cannot agree upon a sole Arbitrator, each party shall pick an Arbitrator who is a dentist licensed in California and the two Arbitrators shall pick a third dentist proceeding under the rules of the American Arbitration Association. Notwithstanding the foregoing, two additional Arbitrators who are dentists may be added by the parties by agreement in writing to create an arbitration panel of three. It is agreed that all parties relevant to a full and complete settlement of any dispute subject to this agreement may be intervened or joined.

ARTICLE 3. The prevailing party in any arbitration pursuant to this agreement shall be awarded all cost, including reasonable attorneys' fees and arbitrators' fees, in prosecuting or defending the claim in arbitration, but not to exceed $5,000 in amount. Furthermore. I f any action is taken to set aside or otherwise attack the binding arbitration award, the losing party in the court action shall bear all the prevailing party's costs, including reasonable attorneys' fees.

ARTICLE 4. Any party initiating arbitration under this agreement shall file with his petition a bond or cash surety in the amount equal to Five Hundred Dollars ($500) which shall provide security for attorneys' fees and costs in the event that the moving party shall not prevail.

ARTICLE 5. This agreement shall govern all future services rendered to Patient by Doctor and Doctor's Affiliates and Associates. Execution of this agreement is a precondition to the furnishing of services by Doctor, but this agreement may be rescinded by written notice by either party within thirty days of signature. After those thirty days, this agreement may be changed or revoked only by a written revocation signed by both parties.

ARTICLE 6. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist nor Consumer Dental Network is responsible for my dental treatment.

ARTICLE 7. Doctor hereby agrees to render dental care and service to Patient. Patient agrees to pay Doctor promptly upon the rendering of a bill at the currently prevailing rates, or to cooperate with Doctor in obtaining payment from third party payers.

ARTICLE 8. Except for the fact that Doctor has indicated professional services will not be rendered to Patient unless this agreement is executed. Doctor has made no other representations or statements, oral or written, to induce Patient to execute this agreement.

ARTICLE 9. In the event that any provision of this agreement shall be void or unenforceable for any reason whatsoever, then such provision shall be stricken and of no force and effect. The remaining provisions of this agreement, however, shall continue in full force and effect, and to the extent required, shall be modified to preserve their validity. This agreement shall be governed by California law.

THIS IS A BINDING LEGAL DOCUMENT WHICH MAY HAVE AN IMPORTANT EFFECT ON YOUR LEGAL RIGHTS. CONSULT YOUR ATTORNEY ON ANY QUESTIONS YOU MAY HAVE.

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

_____
PATIENT'S SIGNATURE

_____
PATIENT'S AGENT OF REPRESENTATIVE

_____
RELATIONSHIP TO PATIENT

_____
DOCTOR

_____ / _____ / _____ / _____ : _____ AMPM
TRANSLATED BY — MONTH — DATE — YEAR — TIME

HOVSEP NARGIZYAN, D.D.S

1655 N. Mount Vernon Ave.
San Bernardino, CA 92411

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I _____,acknowledge that I have received from HOVSEP NARGIZYAN, D.D.S a copy of the Dental Materials Fact Sheet dated October 2001

Patient's Signature: _____Date:___/___/___