Arnold Cutler, D.D.S., Inc.
GENTLE DENTISTRY

9927 CHANNEL ROAD • LAKESIDE, CA 92040-3003 • (619) 561-3307

Dear New Friend,

Welcome! Each time you come to our office we want you to have a pleasant wonderful experience.

Your satisfaction and care is our top priority. We have an excellent staff that is highly trained and available to serve your every need.

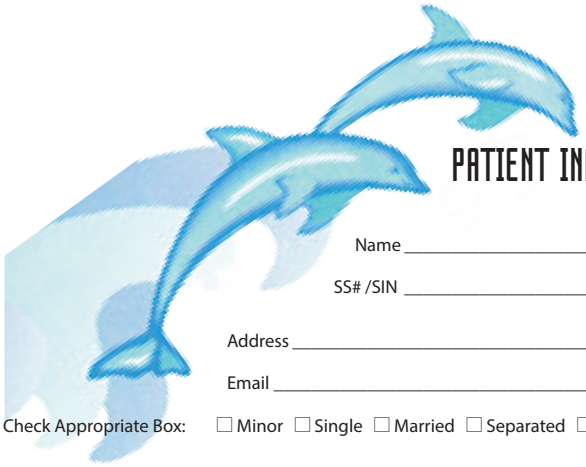
We appreciate the opportunity to serve you and your family. Please let us know if you have any special requests.

Sincerely,

Arnold Cutler, DDS

Arnold Cutler, D.D.S.

P.S. Remember everything we do is 100% guaranteed. Please make yourself comfortable.



THANK YOU FOR SELECTING OUR DENTAL TEAM

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Patient Number _____

Name _____ Date _____

SS# /SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State/ Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods/of payment. Please check the option you prefer. Payment in full at each appointment..

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Do You Have Any Additional Insurance? ☐ Yes ☐ No If Yes, Complete the Following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

Insurance Company _____ Group # _____ Policy/ID# _____

Ins. Co. Address _____ City _____ State/ Prov. _____ Zip/ P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medications) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
11. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other_____	☐	☐

PATIENT DENTAL HISTORY

Name of Previous Dentist _____ Date of Last Exam _____

Previous Dentist's Location _____ Date of Last Cleaning_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement_____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

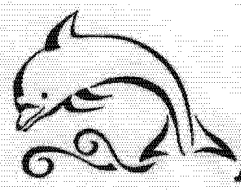
X_____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

_____

_____Signature _____Date _____



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WELCOME TO DR. CUTLER'S DENTAL OFFICE

It is our primary goal to provide you and your family with the highest quality of dental care while keeping a friendly and relaxing environment. In order to keep our standard of care to a level that best services your dental needs, we ask you to please observe the following guidelines.

CANCELLATION POLICY:

There are many times that our patients require urgent emergency treatment and therefore require immediate attention, When patients give the office advanced notice of their need to cancel a schedule appointment, this time can then be transferred to those patients with urgent need of treatment. In this way the office can serve the needs of ALL patients.

Bearing in mind these special needs of others, the office requires a minimum of 24 hours notice if an appointment must be cancelled, if less than a 24 hour notice has been giving to cancel an appointment, a $50.00 fee will be charged. If the patient does not give any notice and does not show up for their reserved appointment, then a $75.00 fee will be charged. Please note that this fee is NOT covered by dental insurances and payment is the PAITENTS responsibility, and needs to be paid before the appointment can be rescheduled.

*Exceptions will be made for illness and personal tragedy.

PAYMENT POLICY:

Unless prior arrangements have been made, payment is due upon completion of treatment. Please note, not ALL services may be covered by your insurance carrier and every insurance plan has its own unique "quirks" and exceptions. It becomes the patient's responsibility to cover the cost of procedures that are not covered by their insurance plan.

We at DR. Cutler's Dental Office look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals.

I HAVE READ AND AGREE WITH THE ABOVE POLICIES OF DR. CUTLER'S OFFICE AND UNDERSTAND MY RESPONSIBILITY AS A PATIENT.

PATIENT SIGNATURE:

_____

DATE: _____

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All Media Release Form

Name:_____

I hereby consent for Arnold Cutler,DDS, Inc. to use, reproduce, exhibit or distribute (in full or part) any photographic,video, film, and/or audio recordings made of me or my likeness; and/or any written extract of such recordings in which I may be included, for any purpose whatsoever, in any medium now known or in the future invented.

I hereby release, discharge, and agree to hold harmless Arnold Cutler, DDS, Inc. and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio, or photographic production.

Talent signature:_____

Talent Print Name:_____

Date: _____

Address:_____

City:_____State:_____Zip:_____

If talent is a minor under the laws of the state where acting or performing is done:

Legal Guardian:_____ (print name)

Signature:_____

Date:_____

Address:_____

City:_____State:_____Zip:_____