

Welcome to Riverbank Modern Dentistry / Bienvenido a Riverbank Modern Dentistry

We appreciate the trust placed in us to provide your dental care. Please complete this form as accurately as possible.

Patient Information / Información del Paciente

Last Name (Apellido):	First Name (Nombre):	Middle Name (Segundo Nombre):
Preferred Name (Nombre Preferido):	Date of Birth / Age (Fecha de Nacimiento / Edad):	SSN # (Seguro Social):
<input type="checkbox"/> Male / Masculino	<input type="checkbox"/> Female / Femenino	<input type="checkbox"/> Other / Otro
<input type="checkbox"/> Single / Soltero(a)	<input type="checkbox"/> Married / Casado(a)	<input type="checkbox"/> Domestic Partner / Pareja
<input type="checkbox"/> Widowed / Viudo(a)	<input type="checkbox"/> Child / Minor / Niño	<input type="checkbox"/> Prefer not to say / Prefiero no decir
Occupation (Ocupación):	Employer (Empleador):	
Email Address (Correo Electrónico):		
Cell / Celular:	Home Phone (Teléfono de Casa):	Work Phone (Teléfono del Trabajo):

Home Address / Dirección de Casa

Street Address (Dirección):		
City (Ciudad):	State (Estado):	ZIP Code (Código Postal):

Billing Address (if different) / Dirección de Facturación (si es diferente)

Street Address (Dirección):		
City (Ciudad):	State (Estado):	ZIP Code (Código Postal):

Emergency Contact / Contacto de Emergencia

Emergency Contact Name (Nombre del Contacto):	Relationship (Relación):
Phone (Teléfono):	Alternate Phone (Teléfono Alterno):

Responsible Party (if different from patient) / Persona Responsable (si es diferente)

Responsible Party Name (Nombre):	SSN #:	
Date of Birth (Fecha de Nacimiento):	Relationship to Patient (Relación al Paciente):	Driver's License # & State (Licencia y Estado):

Insurance Information / Información de Seguro
Primary Dental Insurance / Seguro Dental Primario

Insurance Company (Compañía de Seguro):	Policy / ID # (Número de Póliza):	Group # (Número de Grupo):
Subscriber Name (Nombre del Asegurado):	Subscriber DOB (Fecha de Nacimiento):	Subscriber SSN # (SSN del Asegurado):

Secondary Dental Insurance / Seguro Dental Secundario

Insurance Company (Compañía de Seguro):	Policy / ID # (Número de Póliza):	Group # (Número de Grupo):
Subscriber Name (Nombre del Asegurado):	Subscriber DOB (Fecha de Nacimiento):	Subscriber SSN # (SSN del Asegurado):
How did you hear about us? (¿Cómo se entero?):		Previous Dentist's Name (Dentista anterior):

Physician Information Información del Médico		
Primary Care Physician (<i>Nombre del Médico</i>):		Physician Phone (<i>Teléfono del Médico</i>):
Physician Address / Practice (<i>Dirección del Médico</i>):		
What brings you in today? / Chief Complaint (<i>¿Qué le trae hoy?</i>):		
Dental History Historia Dental		
Date of Last Cleaning (<i>Última Limpieza</i>):		Date of Last X-Rays (<i>Últimas Radiografías</i>):
1. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Are you currently in pain?	¿Tiene dolor actualmente?
2. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Do your gums bleed when you brush or floss?	¿Le sangran las encías al cepillarse o usar hilo dental?
3. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Are your teeth sensitive to hot, cold, or other?	¿Son sus dientes sensibles al calor, frío u otros?
4. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Do you have pain or clicking in your jaw (TMJ)?	¿Tiene dolor o clic en la mandíbula (ATM)?
5. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Have you ever had gum (periodontal) treatment?	¿Ha tenido tratamiento de encías?
6. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Difficult problem with previous dental work?	¿Problemas con trabajos dentales anteriores?
Brush per day (<i>Cepillo / día</i>):		Floss per day (<i>Hilo dental / día</i>):
<input type="checkbox"/> Excellent / Excelente <input type="checkbox"/> Good / Bueno		<input type="checkbox"/> Fair / Regular <input type="checkbox"/> Poor / Malo
Current dental health (circle) (<i>Salud dental actual</i>)		
General Health History Historia General de Salud		
I. General / I. General		
1. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Is your general health good?	¿Está en buena salud general?
2. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Has your health changed in the past year?	¿Han habido cambios en su salud en el último año?
3. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Hospitalized or serious illness in last 3 years?	¿Hospitalizado o enfermedad grave en 3 años?
4. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Currently under care of a physician?	¿Bajo cuidado médico actualmente?
If yes, why / for what condition? (<i>Si sí, ¿por qué / para qué?</i>):		
Date of Last Medical Exam (<i>Fecha del Último Examen</i>):		Treating Physician / Specialist (<i>Médico Tratante</i>):
II. Have You Experienced? / II. ¿Ha Notado?		
5. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Bleeding problems, bruising easily?	¿Problemas de sangrado, moretones?
6. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Fainting spells?	¿Desmayos?
7. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Seizures?	¿Convulsiones?
III. Do You Have or Have You Had? / III. ¿Tiene o Ha Tenido?		
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Heart disease or heart attack <i>Enfermedades del corazón</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Angina <i>Angina de pecho</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Arthritis or rheumatism <i>Artritis o reumatismo</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Heart murmur <i>Soplo en el corazón</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Congenital heart defect <i>Defecto cardíaco</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Eye diseases <i>Enfermedades de los ojos</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Heart valve problem / Mitral prolapse <i>Válvula / Prolapso mitral</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Irregular heartbeat / Tachycardia <i>Latido irregular</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Skin diseases <i>Enfermedades de la piel</i>

<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Stroke or TIA <i>Apoplejía o AIT</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Rheumatic fever <i>Fiebre reumática</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Anemia or blood disorders <i>Anemia o sangre</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No High or low blood pressure <i>Presión alta o baja</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Taking heart medication / blood thinners <i>Medicamento cardíaco</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Sexually transmitted infection <i>Infección sexual</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Asthma, COPD, emphysema <i>Asma, EPOC, enfisema</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Chronic cough / Tuberculosis <i>Tos crónica / TB</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Herpes <i>Herpes</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Hepatitis or liver disease <i>Hepatitis o hígado</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Stomach problems, ulcers, GERD <i>Problemas est., reflujo</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Kidney or bladder disease <i>Enfermedad renal</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No HIV / AIDS <i>VIH / SIDA</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Thyroid or adrenal disease <i>Enfermedad de tiroides</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Diabetes (Type 1 or 2) <i>Diabetes (Tipo 1 o 2)</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Osteoporosis <i>Osteoporosis</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Bisphosphonates / Fosamax <i>Bifosfonatos / Fosamax</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Mental health condition <i>Condición de salud mental</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Sleep apnea or loud snoring <i>Apnea del sueño</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Tumors or cancer <i>Tumores o cáncer</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Joint replacement / artificial joint <i>Articulación artificial</i>
IV. Have You Ever Had? / IV. ¿Alguna Vez Ha Tenido?		
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Psychiatric / psychological treatment <i>Tratamiento psiquiátrico</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Radiation therapy / Cancer radiation <i>Terapia de radiación</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Chemotherapy <i>Quimioterapia</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Prosthetic heart valve <i>Válvula cardíaca artificial</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Pacemaker or defibrillator <i>Marcapasos / desfibrilador</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Organ transplant <i>Trasplante de órgano</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Blood transfusion <i>Transfusión de sangre</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Hospitalization (past 5 yrs) <i>Hospitalización (5 años)</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Reaction to dental treatment or injections <i>Reacción a tratamiento dental</i>
IV-A. Other Conditions / IV-A. Otras Condiciones		
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No ADD / ADHD <i>ADD / TDAH</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Anxiety <i>Ansiedad</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Autism <i>Autismo</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Auto immune disease <i>Enfermedad autoinmune</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Bipolar disorder <i>Trastorno bipolar</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Birth defects <i>Defectos de nacimiento</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Cerebral palsy <i>Parálisis cerebral</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Deaf / hearing impaired <i>Sordera</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Depression <i>Depresión</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Disc deterioration <i>Deterioro de disco</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Easily winded <i>Se cansa fácilmente</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Fibromyalgia <i>Fibromialgia</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Glaucoma <i>Glaucoma</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Head injury <i>Lesión en la cabeza</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Hyper/Hypothyroid disease <i>Tiroides</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Neck / back problems <i>Problemas de cuello/espalda</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No PTSD <i>TEPT</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Schizophrenia <i>Esquizofrenia</i>
<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Seizures / Epilepsy <i>Convulsiones / Epilepsia</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Sleep apnea or snoring <i>Apnea del sueño</i>	<input type="checkbox"/> Yes/Sí <input type="checkbox"/> No Other psychiatric condition <i>Otra condición psiquiátrica</i>
V. Allergies / V. Alergias		
<input type="checkbox"/> Aspirin / <i>Aspirina</i>	<input type="checkbox"/> Any other NSAIDs / <i>Otros AINEs</i>	<input type="checkbox"/> Penicillin / Amoxicillin / <i>Penicilina/Amoxicilina</i>
<input type="checkbox"/> Codeine / <i>Codeína</i>	<input type="checkbox"/> Erythromycin / <i>Eritromicina</i>	<input type="checkbox"/> Clindamycin / <i>Clindamicina</i>
<input type="checkbox"/> Azithromycin / <i>Azitromicina</i>	<input type="checkbox"/> Tetracycline / <i>Tetraciclina</i>	<input type="checkbox"/> Keflex / Cephalosporins / <i>Keflex/Cefalosporinas</i>

<input type="checkbox"/> Sulfa drugs / Medicamentos con sulfa	<input type="checkbox"/> Naproxen / Naproxeno	<input type="checkbox"/> Ibuprofen / Advil / Ibuprofeno
<input type="checkbox"/> Tylenol / Tylenol	<input type="checkbox"/> Vicodin / Hydrocodone / Vicodin	<input type="checkbox"/> Dental Anesthetic Allergy / Alergia a Anestesia Dental
<input type="checkbox"/> Latex / Rubber / Látex / Hule	<input type="checkbox"/> Iodine / Shellfish / Yodo / Mariscos	<input type="checkbox"/> Metal / Jewelry / Metal / Joyas
<input type="checkbox"/> Tape or Other Skin Allergies / Cinta o Alergias de Piel	<input type="checkbox"/> Foods (specify below) / Alimentos	<input type="checkbox"/> Other (specify below) / Otro
Describe any allergies or reactions in detail (Describe alergias o reacciones en detalle):		
VI. Current Medications & Supplements / VI. Medicamentos Actuales		
39. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Taking prescription, OTC, vitamins, or supplements?	¿Tomando medicamentos, vitaminas o suplementos?
40. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Using tobacco in any form?	¿Usando tabaco en cualquier forma?
Please list medications, dose, and frequency (Liste medicamentos, dosis y frecuencia):		
Pharmacy Name & Location (Nombre y ubicación de la farmacia):		
VII. Women Only / VII. Solo Para Mujeres		
41. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Pregnant, possibly pregnant, or nursing?	¿Embarazada o dando pecho?
42. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Taking oral contraceptives or hormones?	¿Tomando anticonceptivos u hormonas?
VIII. All Patients / VIII. Todos Los Pacientes		
43. <input type="checkbox"/> Yes/Sí <input type="checkbox"/> No	Any other disease or medical problem NOT listed above?	¿Otra enfermedad o problema NO mencionado?
If yes, please explain (Si sí, por favor explique):		
Patient Certification & Authorization / Certificación y Autorización del Paciente		
I certify that I have read and understood the above information. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including diagnosis and treatment records to third-party payers and/or health practitioners. I authorize my insurance to pay directly to the dentist and agree to be responsible for all services rendered. I consent to dental x-rays, diagnostic procedures and treatment necessary for dental care. By signing, I authorize electronic communication of my health information and understand I may revoke this in writing at any time.		Yo certifico que he leído y entendido la información anterior. Las preguntas han sido contestadas correctamente. Entiendo que proveer información incorrecta puede ser peligroso. Autorizo al dentista a divulgar mi información a terceros pagadores y/o profesionales de salud. Autorizo a mi seguro a pagar directamente al dentista y acepto ser responsable de todos los servicios. Doy mi consentimiento a radiografías y tratamiento necesario. Al firmar, autorizo comunicación electrónica de mi información de salud.
Patient / Guardian Signature (Firma del Paciente / Tutor):		Date / Fecha:
Printed Name (Nombre en Letra de Molde):	Relationship to Patient (if guardian) (Relación):	Name if not Patient (Nombre si no es el paciente):
For Office Use Only Additional Comments:	Dentist Signature / Firma del Dentista:	Date Reviewed / Fecha de Revisión:



RIVERBANK MODERN DENTISTRY
Dental Practice of Maulik Shah, DDS, Inc.
2603 Patterson Rd, Suite #5, Riverbank, CA 95367
ARBITRATION AGREEMENT

CALIFORNIA NOTICE (CCP §1295): BY SIGNING THIS AGREEMENT 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. THIS AGREEMENT IS PROVIDED SEPARATELY FROM OTHER INTAKE FORMS. YOU MAY SEEK LEGAL COUNSEL BEFORE SIGNING AND MAY REVOKE THIS AGREEMENT IN WRITING WITHIN 30 DAYS OF SIGNING.

PARTIES: This Agreement is between **Riverbank Modern Dentistry, Dental Practice of Maulik Shah, DDS, Inc.**, its dentists, employees, hygienists, assistants, contractors, agents, and assigns (collectively "Provider") and the undersigned patient or legal representative ("Patient").

1. AGREEMENT TO ARBITRATE

Patient and Provider agree that any dispute arising out of or related to dental examination, diagnosis, treatment, informed consent, prescriptions, referrals, records, billing, insurance, privacy, professional negligence, malpractice, breach of contract, emotional distress, personal injury, wrongful death, or any other aspect of the provider-patient relationship shall be resolved exclusively by **final and binding arbitration** — not by jury or court trial — except as required by California law. **Emergency treatment where Patient was unable to sign is excluded** from this Agreement.

2. SCOPE & APPLICATION

This Agreement applies to services rendered on or after the date of signing only. It binds Patient, their heirs, estate, legal representatives, and wrongful death beneficiaries consistent with California law (Ruiz v. Podolsky, 50 Cal.4th 838). It does not apply retroactively to prior services.

3. ARBITRATION PROCESS

Arbitration shall be conducted through **AAA (Healthcare Rules)** or **JAMS**, or another mutually agreed service, in Stanislaus County, CA. If neither is available, either party may petition a California Superior Court to appoint a neutral arbitrator per CCP §1281.6, with selection completed within 60 days of demand. The arbitrator shall decide all issues of law and fact and may award any relief permitted by law. The decision is final and binding per CCP §§1286.2 and 1286.6.

4. FEES & COSTS

Patient's share: Patient pays arbitration filing fees and a share of arbitrator fees, **capped at a total maximum of \$700** regardless of claim size or duration.

Provider's share: Provider pays all arbitration costs above \$700.

Loser-pays: If Provider prevails, Patient reimburses Provider for Patient's arbitration costs up to the \$700 cap. If Patient prevails, Provider absorbs all costs.

Hardship waiver: If Patient demonstrates genuine financial hardship, Provider has sole discretion to reduce or waive Patient's portion to ensure cost is not a barrier to legitimate claims.

Attorney fees: Each party bears its own attorney fees unless required by law or awarded by the arbitrator.

5. DISCOVERY

Each party is entitled to a minimum of two (2) depositions, one (1) retained expert witness, document production within 30 days of request, and expert disclosure at least 45 days before the hearing. The arbitrator may adjust these limits for good cause.

6. ADDITIONAL TERMS

No class claims: All disputes shall be resolved individually and not consolidated with other patients' claims except as required by law.

Severability: If any provision is found unenforceable, all remaining provisions stay in full force.

Survival: This Agreement survives completion of treatment, termination of the provider-patient relationship, and Patient's death or incapacity.

Electronic signatures: Electronic, typed, or stylus signatures carry the same legal effect as handwritten signatures under E-SIGN and California law.

Governing law: Governed by the Federal Arbitration Act, California arbitration law (CCP §§1280–1294.4), and CCP §1295 where applicable.

Right to revoke: Patient may revoke this Agreement by written notice within 30 days of signing, delivered to: Riverbank Modern Dentistry, 2603 Patterson Rd, Suite #5, Riverbank, CA 95367. Revocation does not affect services already rendered or disputes already in arbitration.

Entire agreement: This Agreement supersedes all prior understandings on dispute resolution and may only be modified in writing signed by both parties.

BY SIGNING BELOW, PATIENT CONFIRMS AND AGREES TO ALL OF THE FOLLOWING:



(1) Patient has read or had a reasonable opportunity to read this entire Agreement, which was provided as a **separate standalone document** from all other intake paperwork. (2) Patient has had the opportunity to ask questions and to seek **independent legal counsel** before signing. (3) Patient understands that by signing, Patient is **waiving the right to a jury or court trial** for all covered disputes and that arbitration decisions are generally final and binding. (4) Patient understands the right to **revoke this Agreement within 30 days** of signing by delivering written notice to Provider at the address above. (5) Patient is signing this Agreement **freely and voluntarily, without pressure or coercion** of any kind. (6) This Agreement was presented and explained in a language Patient understands. (7) Patient **is able to read and understand this Agreement in English**, or confirms that it was fully translated and explained to their satisfaction in a language they understand prior to signing, and that they had no unanswered questions before signing.

Patient / Legal Representative Signature:

Printed Name:

Relationship to Patient (if signing on behalf of patient):

Date Signed:

Provider Representative Signature:

This document is digitally signed by Maulik Shah, DDS - President of Maulik Shah, DDS, Inc DBA Riverbank Modern Dentistry. This digital signature is provided exclusively for the execution of the attached Arbitration Agreement ("Agreement") between Riverbank Modern Dentistry ("Dental Office"), Maulik Shah, DDS, its associates, employees, agents, and representatives (collectively, "Provider"), and the undersigned patient or legal representative ("Patient"). This signature is legally binding only for this specific document and its associated transaction. Any other use, reproduction, or transfer of this digital signature to another document, transaction, or communication without the explicit written consent of Maulik Shah, DDS is strictly prohibited and considered invalid.

Provider Printed Name / Title: Maulik Shah, DDS

Date Signed:

MASTER ELECTRONIC ACKNOWLEDGMENT AND CONSENT

Riverbank Modern Dentistry

Dental Practice of Maulik Shah, DDS, Inc.
2603 Patterson Rd, Suite #5, Riverbank, CA 95367

Patient Name: _____ **Date of Birth:** ____ / ____ / ____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF POLICIES, NOTICES, CONSENTS, ELECTRONIC RECORDS, AND ELECTRONIC SIGNATURES

I acknowledge that Riverbank Modern Dentistry, Dental Practice of Maulik Shah, DDS, Inc. ("Practice"), has provided me access to the following documents, policies, notices, disclosures, and consents in electronic and/or paper form:

1. Notice of Privacy Practices (HIPAA)
2. Insurance and Financial Policy
3. Electronic Communication Consent (Email, Text, Portal)
4. Communicable Disease / Infection Control Acknowledgment
5. Dental Materials Fact Sheet

QR Code to Access All Current Policies, Notices, Disclosures & Consents:



By signing below, I acknowledge, represent, and agree as follows:

- I have been provided a reasonable opportunity to review all documents listed above before treatment.
- I understand that printed copies are available upon request.
- I understand that these documents may be updated periodically in accordance with applicable law and office policy.
- I understand that my continued treatment with the Practice may be subject to applicable updated policies and procedures.
- I understand that electronic signatures, electronic records, and electronic acknowledgments shall have the same legal force and effect as original handwritten signatures to the fullest extent permitted by applicable federal and California law, including the California Uniform Electronic Transactions Act.
- I understand Electronic, typed, or stylus signatures carry the same legal effect as handwritten signatures under E-SIGN and California law.
- I understand that the Practice may maintain these records electronically.
- I understand that electronically stored records may be reproduced and relied upon as business records in any administrative, insurance, arbitration, or legal proceeding.
- I certify that the information and representations I provide to the Practice are truthful and accurate to the best of my knowledge.
- I understand that the Practice is relying upon my representations in providing treatment, scheduling appointments, communicating with me, and processing insurance or financial arrangements.

- I acknowledge that I have had the opportunity to ask questions regarding these documents and have either received satisfactory answers or voluntarily declined additional explanation.
- I acknowledge that no guarantee or assurance has been made regarding treatment outcomes, insurance payment, or financial estimates unless specifically provided in writing.

LANGUAGE / TRANSLATION CERTIFICATION

By signing below electronically, I acknowledge that I have reviewed and agree to the terms of this document. I understand that my electronic signature is legally binding and has the same legal effect as a handwritten signature.

By signing electronically, the patient acknowledges they understand this document or have had it translated/explained in a language they understand.

I certify and acknowledge that: I can read and understand English; OR The contents of the documents presented to me have been translated, interpreted, or explained to me in a language I understand.

I further acknowledge that:

- I have had the opportunity to ask questions regarding the documents and information presented;
- my questions have been answered to my satisfaction;
- I understand the general nature and purpose of the documents I am signing;
- and I am signing voluntarily and without coercion.

If an interpreter, translator, family member, or third party assisted me, I understand that Riverbank Modern Dentistry may rely on my acknowledgment that I understood the information provided.

Al firmar electrónicamente a continuación, reconozco que he revisado y acepto los términos de este documento. Entiendo que mi firma electrónica es legalmente vinculante y tiene el mismo efecto legal que una firma manuscrita.

Al firmar electrónicamente, el paciente reconoce que comprende este documento o que le ha sido traducido o explicado en un idioma que comprende.

Certifico y reconozco que: Puedo leer y comprender el español; O El contenido de los documentos que me han sido presentados me ha sido traducido, interpretado o explicado en un idioma que comprendo.

Además reconozco que:

- He tenido la oportunidad de hacer preguntas sobre los documentos e información presentados;
- mis preguntas han sido respondidas a mi satisfacción;
- comprendo la naturaleza general y el propósito de los documentos que estoy firmando;
- y estoy firmando voluntariamente y sin coacción.

Si un intérprete, traductor, familiar o tercero me asistió, entiendo que Riverbank Modern Dentistry puede basarse en mi reconocimiento de que comprendí la información proporcionada.

Patient / Guardian Signature	Printed Name of Person Signing:	Date
X _____	_____	_____

Thank you for choosing Riverbank Modern Dentistry. We look forward to providing you with exceptional care. If you have any questions about this packet, please ask a team member before signing.