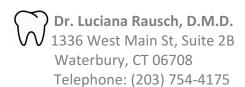


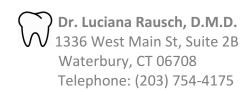
# PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM	DATE
PATIENT'S NAME	
DATE OF BIRTH	PHONE
PATIENT'S ADDRESS	
TOWN / CITY STATE	ZIP CODE
PERSON RESPONSIBLE FOR THIS ACCOUNT	PHONE
DENTAL	HISTORY
CHIEF ORAL COMPLAINT	
DATE OF LAST DENTAL EXAM ANY PREV	
DO YOU HAVE OR DO YOU USE ANY OF T	THE FOLLOWING – INDICATE WITH A ( √ )
_	<u>_</u>
☐ Teeth sensitive to cold, heat, sweets or pressure ☐ Bleeding gums. How long	<ul><li>☐ Periodontal treatment</li><li>☐ Orthodontic treatment</li></ul>
Food Impaction	☐ Mouth breathing
☐ Clenching or grinding	☐ Oral habits, i.e., fingernail biting, cheek biting
☐ Burning of tongue	☐ Cigarettes, pipe or cigar smoking
☐ Swelling or lumps in mouth	☐ Texture of toothbrush
☐ Frequent blisters on lips or mouth	☐ Frequency of brushing
☐ Pain around ear	☐ Dental floss
☐ Unusual sounds in ear while eating	☐ Interdental stimulators
☐ Bad breath	☐ Water jet device
☐ Unpleasant taste	☐ Disclosing tablets or solution
☐ Unfavorable dental experience	☐ Fluoride supplements
☐ Complications from extractions	☐ Alcohol



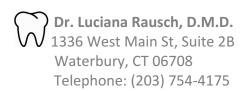
## **MEDICAL HISTORY**

PHYSICIAN'S NAME	DATE OF LAST PHYSICAL EXAM
DO YOU HAVE OR DO HAVE YOU HAD A	NY OF THE FOLLOWING – INDICATE WITH A ( $\checkmark$ )
☐ Allergies to drugs	☐ Liver problems or hepatitis
☐ Allergies to anesthetics	☐ Malignancies
☐ Any heart ailments	☐ Psychiatric care/emotional problems
☐ High blood pressure	☐ Rheumatic fever
☐ Neurological problems	☐ Sinus problems
☐ Radiation treatments	☐ Immune System Disorders (AIDS, HIV, ARC)
☐ Excessive bleeding from cut or extraction	☐ Stroke
☐ Anemia or blood problems	☐ Thyroid
☐ Arthritis	☐ Eye disorders
☐ Chronic Fatigue Syndrome	☐ Tonsillitis
☐ Asthma	☐ Tuberculosis
☐ Hay fever or allergies in general	☐ Ulcer or colitis
□ Diabetes	☐ Pregnancy. If so, what month
☐ Kidney problems	☐ Venereal disease
☐ Latex sensitivity	☐ Other
Describe any current medical treatment including d	rugs taken, even though not listed above
INSURANCE: To avoid misunderstandings regarding dent	tal insurance, we wish our patients to know that all professional
	d that patients are personally responsible for payment of fees.
	obtain your benefits from insurance companies, upon receipt of
full (or partial) payment of bill. We do not render our se	rvices on the basis that insurance companies will pay all our fees.
Each fee is individual for the individual patient.	
SIGNATURE	DATE
(PARENT OR GUAF	RDIAN, IF PATIENT IS A MINOR)



# **DENTAL INSURANCE INFORMATION**

NAME OF INSURED			
INSURED'S BIRTH DATE	ID # OR SSN	GROUP #	
INSURED'S ADDRESS			
TOWN / CITY	STATE	ZIP CODE	
INSURED'S EMPLOYER NAME			
TOWN / CITY			
PATIENT'S RELATIONSHIP TO INSUR	ED: SELF SPOUSE C	CHILD OTHER	
INSURANCE PLAN NAME			
INSURANCE ADDRESS			
TOWN / CITY	STATE	ZIP CODE	
	G INFORMATION ONLY IF YOU I	HAVE A SECONDARY DENTAL INSURA	NCE:
NAME OF INSURED			
INSURED'S BIRTH DATE	ID # OR SSN	GROUP #	
INSURED'S ADDRESS			
TOWN / CITY	STATE	ZIP CODE	
INSURED'S EMPLOYER NAME			
EMPLOYER'S ADDRESS			
TOWN / CITY			
PATIENT'S RELATIONSHIP TO INSUR	ED: SELF SPOUSE C	CHILD OTHER	
INSURANCE PLAN NAME			
INSURANCE ADDRESS			
TOWN / CITY	STATE	7IP CODE	



### **HIPAA CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

- Treatment including direct or indirect treatment by other healthcare providers involved in my case.
- Payment: we may use and disclose your health information to obtain payment for services we provide to you.
- The day-to-day healthcare operations of our practice in relation to your treatment.

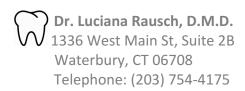
I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice periodically and that I may contact you at any time to obtain the most current copy of this notice.

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, then you are bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature	<del></del>
Printed Name	Date
(Relationship to patient)	



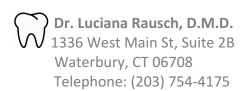
#### CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured website for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any changes, damages or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance and storage of my information and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the website for the dental practice, and grant the dental practice permission to securely upload my patient information to the website.

SIGNATURE	DATE
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)	
(Relationship to patient)	



#### **CONSENT FOR SERVICES**

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credits any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

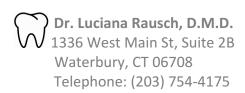
A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me to discuss this sta	atement or my treatment.
I have read the above conditions of treatment and payment and agree to their c	ontent.
SIGNATURE(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)	DATE

(Relationship to patient)



### **CANCELLATION POLICY**

Dear patient,

We are committed to meeting our patients dental care needs. "No-shows" and late cancellations waste precious time that other patients could use and they should not be asked to subsidize your broken appointments through higher fees than necessary. In an effort to reduce the number of such occurrences, we have the following cancellation policy.

Please, be advised that:

- All appointments must be cancelled with a 24 hours notice to avoid charges for a "no-show" or late
  cancellation;
- A "no-show" / late cancellation fee of \$50.00 per half hour of appointment time will be charged into your account;
- If you are late for an appointment, you will be seen as soon as possible, at our staff's convenience, though the office visit may need to be shortened in length;
- Our office makes reminder calls for appointments. However, it is ultimately the patient's responsibility to remember their scheduled appointments.

Please note that your insurance will not cover charges for a "no-show" / late cancellation fee; therefore, you, as a patient, are directly responsible for the payment and would not be able to schedule future appointments until the fee is paid in full. The balance is expected in a timely fashion and if not, will be subject to collections.

If you have any questions regarding billing, please call our office at (203) 754-4175 during our regular business hours.

We thank you for trusting our office with your dental care!

I have read the document and understand that I will be financially responsible for all missed scheduled appointments that are not cancelled as described in the policy above.

Signature		
Printed Name	Date	