We are pleased you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office? _____

Patient Information

Date ____ Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (Unit#) _____ (City) _____ (State) _____ (Zip)

Home Ph. # (____) _____ Work Ph. # (____) _____ Cell Ph. # (____) _____ Marital Status _____

Soc. Sec. # ___ - ___ - ___ Drivers Lic. # _____ E-Mail: _____

Birthdate ___/___/___ Sex M F If patient is a minor, give parent's/guardian's name _____

Name of nearest relative not living with you _____ Relationship _____

If patient is a full-time student, fill in school name _____

School Address _____ Ph. # (____) _____

Emergency Contact _____ Ph. # (____) _____

Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle)

Soc. Sec. # ___ - ___ - ___ Birthdate ___/___/___ Relationship to Patient _____

Residence _____ (Street) _____ (Apt#) _____ (City) _____ (State) _____ (Zip)

Mailing Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

How long at this address _____ Home Ph.# (____) _____ Work Ph.# (____) _____ Fax# (____) _____

Previous Address (if less than 3 years) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Spouse's Name _____

Soc. Sec. # ___ - ___ - ___ Birthdate ___/___/___ Work Ph.# (____) _____ Fax# (____) _____

Employer _____ Occupation _____ No. Years Employed _____

Employer Address _____

Insurance Information

Insured's Name _____ Insured's SS# _____ Insured's DOB _____ ID# _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # (____) _____

Insured's Employer _____ Ph. # (____) _____

Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**

Insured's Name _____ Insured's SS# _____ Insured's DOB _____ ID# _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Ph. # (____) _____

Insured's Employer _____ Ph. # (____) _____

Dental Information

Do your gums bleed when you brush? Yes ___ No ___

Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure Yes ___ No ___ Sweets Yes ___ No ___

Do you grind or clench your teeth? Yes ___ No ___

Do you have any fear of dental work? Yes ___ No ___

Date of last dental visit _____ What was done at the time? _____

Former Dentist Name _____ City _____

How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

Medical Information

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the last two years? YES NO
3. Are you now taking any medication or drugs? YES NO

   If yes, please list:

4. A. Have you taken any medication or drugs during the last two years? YES NO
   B. Have you ever taken bisphosphonate medications for Osteoperosis or other bone loss related issues? YES NO
5. Have you been under the care of a medical doctor during the last two years? YES NO

   Physician's Name ___ Ph. # ( )

   Address
6. Are you sensitive or allergic to any medication or anesthetics? YES NO

   If yes, please list:
7. Indicate which of the following you have had or have at the present. Circle "yes or no" to each item.

Heart Failure	YES	NO	Osteoporosis	YES	NO	Hepatitis	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	If yes, which strain? (circle)	A	B C
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Anemia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Yellow Jaundice	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Tumors	YES	NO
Allergy to Latex	YES	NO	Allergy to Metal (jewelry, etc.)	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO
						If yes, date		

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day? YES NO
10. Do you use more than two pillows to sleep? YES NO
11. Have you lost or gained more than ten pounds in the past year? YES NO
12. Do you ever wake up from sleep and feel short of breath? YES NO
13. Are you on a special diet? YES NO
14. Do you have or have you had any disease, condition, or problem not listed? YES NO

    If yes, please list:
15. Do you smoke? YES NO

FOR WOMEN ONLY:
Are you pregnant? Yes What month? ___ No Are you nursing? Yes No Are you taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient/Guardian Signature ___ Date ___

Print Name ___

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for the patient's treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number &/or insurance identification number to file my dental claim.

Patient ___ Date ___ Witness ___

Print Name ___

Guardian/Responsible Party if minor ___ Relationship to Patient ___

Print Name ___ Date ___

OFFICE USE: Reviewed by Dr. ___ Date ___

FINANCIAL POLICY

This statement is to inform you of our financial policy. Financial arrangements are both necessary and beneficial to maintaining a sound professional relationship. We wish to inform you of our office policy in this regard. Our financial policy is intended to facilitate excellent for you and your family, while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a part of that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. We offer payment plans through third party financing. If you would like more information regarding to the third party financing please check with our financial coordinator.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Additionally, our office will charge you for broken appointments and appointments cancelled without 48-hour advance notice. It is vital you give our office a 48-hour notice to avoid cancelled appointment charges (equivalent to an office visit of $50).

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

_____

Print Name

_____ _____

Signature Date

Medical Center Dental Care
Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ____/____/____, and will remain in effect until we replace it.
We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment:
We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations:
We may use and disclose your health information in connection with our healthcare operations.
Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization:
In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section 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.

Marketing Health-Related Services:
We will not use your health information for marketing communications without your written authorization.
Required by Law:
We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence,
counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction:
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication:
You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.)We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Signature Date

General Dentistry Informed Consent Form

1. **Treatment Plan**
   I understand the recommended treatment and my financial responsibility explained to me. I understand that by signing this consent I am in no way obligated to any treatment, I also acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination. For example root canal therapy following routine restorative procedures.

2. **Drugs and Medications**
   I understand that antibiotics and other medications can cause allergic reactions, such as redness and swelling tissue, itching, vomiting and or anaphylactic shock.

3. **Extractions**
   Alternatives to removal of teeth have been explained to me (root canal therapy, crown and bridge procedures, periodontal therapy etc.) I understand removing teeth does not always remove the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue that can last an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

4. **Crowns, Bridges and Veneers**
   I understand that sometimes it if not possible to match the color of natural teeth exactly with artificial teeth I further understands that may be wearing temporary crowns which come off easily and that I must be careful to ensure that they are kept on until the permanent crown is delivered. I realize the final opportunity to make changes; (shape of fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown or bridge I understand there will be additional charges for remakes due to delaying permanent cementation.

5. **Endodontic Therapy**
   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 root canal filling material may extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses or defects in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root

canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to restore it.

6. **Periodontal Disease**

I understand that I have been diagnosed with a serious condition, causing gum and bone inflammation and/or loss that the result could lead to the loss of teeth. Alternative treatments have been explained to me, including gum surgery, tooth extraction and/or replacement.

7. **Fillings**

I understand that care must be exercised in chewing on filling teeth especially during the first 24 hours to avoid breakage. I understand that a more extensive restorative procedure than originally diagnosed may be required due to additional or extensive decays, I understand that significant sensitivity is a common after effect of newly placed fillings.

8. **Partials and Dentures**

I understand the wearing of partials/dentures is difficult. Sore spots, altered speech and difficulty in eating are common problems. Immediate dentures (placement of dentures immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be need at a later date. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of my partial or denture. I understand that failure to keep my delivery appointment may be result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, additional charges could be incurred.

I understand that dentistry 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 dental treatment, which I have requested.

Patient _____ Date_____

Clinical Staff_____ Date _____