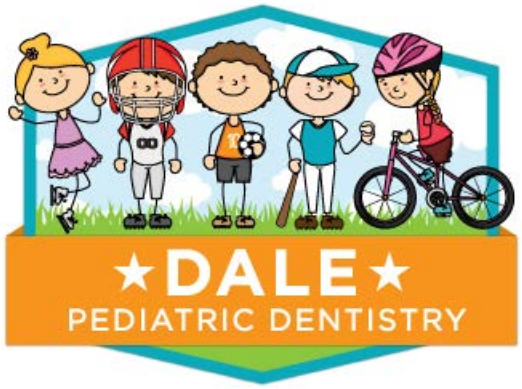

Chart#: FOR OFFICE USE ONLY

Patient Name: Last | First | MI | Preferred Name

Title: Mr/Ms/Mrs/etc **Gender:** Male Female **Family Status:** Married Single Child Other

Birth Date: **SS#:** ___-__-____ **Prev. Visit:**

Email Address: **Best time to call:**

Phone: Home | Mobile | Work | Ext | Fax | Other

Address: Address 1 | Address 2

City | -- State | _____-____ Zip Code

The following is for: the patient the person responsible for payment both not applicable

Employer Name: **Phone:**

Employer Address: Address 1 | Address 2

City | -- State | _____-____ Zip Code

Occupation

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient or if the patient is a minor.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: Last | First | MI | Preferred Name

Title: Mr/Ms/Mrs/etc **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: **SS#:** ___-__-____ **DL#:**

Email Address: **Best time to call:**

Phone: Home | Mobile | Work | Ext | Fax | Other

Address: Address 1 | Address 2

City | -- State | _____-____ Zip Code

Do you have dental insurance? ◯ Yes ◯ No

Primary Dental Insurance:

Name of Insured: Last | First | MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Subscriber ID, Date of Birth, and Insurance Group Number:

Secondary Dental Insurance

Name of Insured: Last | First | MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Subscriber ID, Date of Birth, and Insurance Group Number:

Insurance Authorization:

☐ * **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ **Anxiety Attack**
- ☐ **Artificial Joints**
- ☐ **Aspirin Allergy**
- ☐ **Asthma**
- ☐ **Blood Disease/anemia**
- ☐ **Cancer**
- ☐ **Codeine Allergy**
- ☐ **Diabetes**
- ☐ **Dizziness/Fainting**
- ☐ **Epilepsy**
- ☐ **Epinephrine Reaction**
- ☐ **Excessive Bleeding**
- ☐ **Head/Neck Radiation**
- ☐ **Heart Murmur**
- ☐ **Heart Problems**
- ☐ **Hepatitis A**
- ☐ **Hepatitis B**
- ☐ **Hepatitis C**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **HIV/AIDS**
- ☐ **Kidney Disease**
- ☐ **Latex Allergy**
- ☐ **Liver Disease**
- ☐ **M.V.P. -Mitral Valve**
- ☐ **Novocaine Allergy**
- ☐ **Other**
- ☐ **Pacemaker**
- ☐ **Penicillin Allergy**
- ☐ **PRE-MED**
- ☐ **Respiratory Problems**
- ☐ **Rheumatism**
- ☐ **Seizures**
- ☐ **Sinus Problems**
- ☐ **Stomach Problems**
- ☐ **Stroke**
- ☐ **Sulfa Allergy**
- ☐ **Tuberculosis**
- ☐ **Tumors**
- ☐ **Ulcers**
- ☐ **Valve Replacement**

- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

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- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below: *

Do you take antibiotic premedication for your dental visits? If yes, please explain. *

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician:

When was last physical exam? *

☐ > 1 year ☐ > 2 years ☐ > 5 years ☐ > 10 years ☐ 10+ years

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. *

Dental Information

Previous Dentist Name, Address and Phone Number:*

Date of most recent dental exam:*

Date of most recent dental x-rays:*

Date of last dental cleaning:*

I routinely see my dentist every:*

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

How often do you brush your teeth?*

☐ Once a day ☐ Twice a day ☐ Three times a day
☐ More than three times a day

How often do you floss your teeth?*

☐ Never ☐ Once a day ☐ Twice a day

Do you use a hard or soft toothbrush?*

◯ Hard ◯ Soft

Do you brush your teeth very hard?* ◯ Yes ◯ No

Have you ever had a deep cleaning?* ◯ Yes ◯ No

On a scale of 1 to 10, how important is your oral health to you?*

On a scaled of 1 to 10, how would you rate your oral health?*

Are you happy with the way your teeth look?* ◯ Yes ◯ No

Are you interested in whiter teeth or a nicer smile? ◯ Yes ◯ No

Do you have have problems with: (check all that apply)

☐ Sore gums
☐ Bleeding gums
☐ Loose teeth
☐ Food catching between teeth
☐ Popping, clicking, snapping or pain in your jaw
☐ Swollen gums
☐ Dry mouth/excessive thirst
☐ Difficulty chewing
☐ Clenching or grinding
☐ Bad Breath

Do you have sensitive teeth?

☐ Hot ☐ Cold ☐ Pressure ☐ Sweets

Do you have pain around your ear?

☐ Right ☐ Left

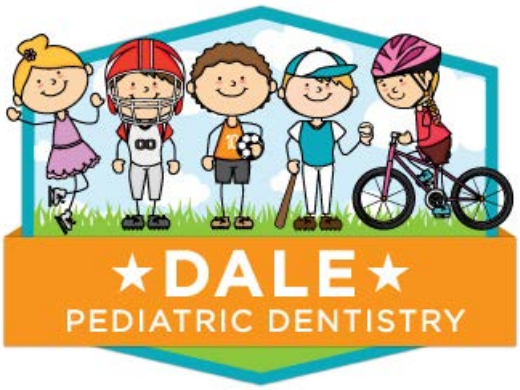
Do you snore when you sleep? ◯ Yes ◯ No

Do you have any broken fillings? ◯ Yes ◯ No

Do you think you have cavities?* ◯ Yes ◯ No

If yes, where?*

Have you had braces before?* ◯ Yes ◯ No



Consent for Services and Financial Policy

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 credit 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 1½% 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 statement or my treatment.

☐ *By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ *By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

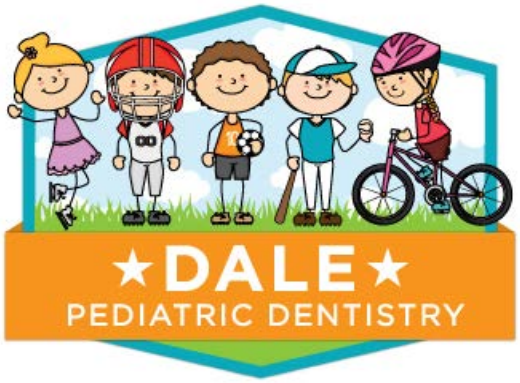
Consent for Internet Communications

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 web site 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 charges, 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 web site 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 web site 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 web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

Signature: _____ Date: _____



GENERAL CONSENT TO TREATMENT

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1. I hereby authorize and direct the dentist(s) of The Dental Pediatric dentistry, to perform dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs, (x-rays), or diagnostic aids.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I agree to the use of local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, enhanced anesthetics, physical restraints and/or voice control depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well-being in the professional judgment of the dentist.

5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result coma or death. I understand and have been informed of the above risks and complications.

6. I also authorize the doctor(s) to use photographs, radiographs and other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.

7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist(s). I agree

that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Signature:_____ Date:_____