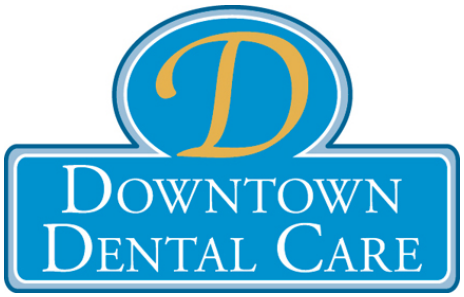

Patient Registration

First Name:_____ MI:_____ Last Name:_____

Birth Date:_____ Social Security #:_____ Sex:_____ Marital Status:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____Employer:_____

Responsible Party (if different than above)

First Name:_____ MI:_____ Last Name:_____

Birth Date:_____ Social Security #:_____ Sex:_____ Marital Status:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Relationship to Patient:_____ Email Address:_____

Dental Insurance (please enter details for primary subscriber)

First Name:_____ MI:_____ Last Name:_____

Relationship to Patient:_____ Social Security #:_____ Birth Date:_____

Insurance Company Name:_____ Ins. Co. Phone #:_____

Ins. Co. Address: _____ City:_____ State:_____ Zip:_____

Subscriber ID #:_____ Group #:_____

How did you hear about us? Internet / Mailers / Movies / Phone Book / Walk-in / Referral / Other_____

If Referral, Patient Name? _____ DDC Employee Name? _____

Patient Signature: _____ Date: _____

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Medical History (PLEASE FILL OUT IN DETAIL .VERY IMPORTANT.THANK YOU!)

Physician Name: _____ Physician Phone #: _____

Emergency Contact: _____ Emergency Contact Phone #: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Allergies (Please circle yes or no)

Aspirin	Y	N
Codeine	Y	N
Dental Anesthetics	Y	N
Erythromycin	Y	N
Jewelry	Y	N
Latex	Y	N
Metals	Y	N
Penicillin	Y	N
Tetracycline	Y	N

List Any Other Allergies: _____

Do You Use Tobacco? Y N

For Women Only (Please Circle yes or No)

Birth Control	Y	N
Are you Pregnant?	Y	N
If so, how many weeks?	_____	
Nursing	Y	N

Please List ALL Medications (including over the counter and herbal supplements)

_____

_____

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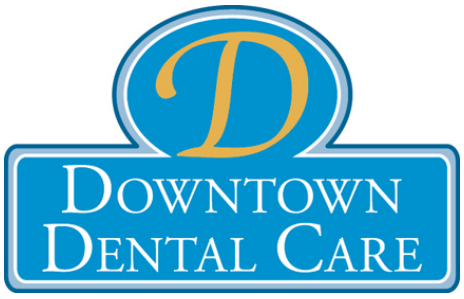

Medical Conditions (PLEASE CIRCLE Yes or No .VERY IMPORTANT.THANK YOU!)

Abnormal Bleeding	Y	N	Heart Attack	Y	N
Alcohol Abuse	Y	N	Heart Surgery	Y	N
Allergies	Y	N	Hemophilia	Y	N
Anemia	Y	N	Hepatitis A	Y	N
Angina Pectoris	Y	N	Hepatitis B	Y	N
Arthritis	Y	N	High Blood Pressure	Y	N
Artificial Bones	Y	N	Kidney Problems	Y	N
Artificial Heart Valve	Y	N	Liver Disease	Y	N
Asthma	Y	N	Low Blood Pressure	Y	N
Blood Transfusion	Y	N	Mitral Valve Prolapse	Y	N
Cancer-Chemotherapy	Y	N	Pace Maker	Y	N
Colitis	Y	N	Pneumocystitis	Y	N
Congenital Heart Defect	Y	N	Psychiatric Problems	Y	N
Cosmetic Surgery	Y	N	Radiation Therapy	Y	N
Diabetes	Y	N	Rheumatic Fever	Y	N
Difficulty Breathing	Y	N	Seizures	Y	N
Drug Abuse	Y	N	Shingles	Y	N
Emphysema	Y	N	Sickle Cell Disease	Y	N
Epilepsy	Y	N	Sinus Problems	Y	N
Fainting Spells	Y	N	Stroke	Y	N
Fever Blisters	Y	N	Thyroid Problems	Y	N
Frequent Headaches	Y	N	Tuberculosis	Y	N
Glaucoma	Y	N	Ulcers	Y	N
HIV+ AIDS	Y	N	Venereal Disease	Y	N
Hay Fever	Y	N	Yellow Jaundice	Y	N
History of Oral Soars	Y	N	Major Surgeries :_____		

Please List any Medical History not addressed below:

_____

Patient Signature: _____ Date: _____

Witness for Doctor: _____Date:_____

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Informed Consent

Potential Risks and Limitations of Dental Treatment

As a rule, excellent dental results can be achieved with informed and cooperative patients. Thus, the following information is routinely supplied to anyone considering dental treatment in our office recognizing the benefits of a pleasing smile and healthy teeth, you should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contra-indicate treatment but should be considered in making the decision to submit to dental treatment.

Perfection is our goal. However, in dealing with human beings, and problems of growth and development, the ravages of dental disease, genetics and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted. We will do everything within our capacity to insure the best possible care.

Throughout life teeth are constantly changing. Periodic examinations should be made so any disease can be treated promptly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and plaque removal is a must.

On rare occasions the nerve of a tooth may die and become infected. A tooth that has been damaged by deep decay, a minor blow or extensive dental treatment can die over a long period of time. An undetected non-vital tooth may flare up during any dental treatment, and may require endodontics (root canal) treatment to maintain it. It may even have to be removed. There is also a risk that during or following treatment soreness or tenderness may occur in the temporomandibular joints (lower jaw joints).

The total time for treatment can be delayed beyond our estimate. Treatment plans can change due to altered conditions which may surface during treatment. Decay which may appear small on x-ray, may be larger than anticipated resulting in much more extensive treatment.

Informed Consent

I understand that during treatment occasionally any of the above problems may occur. These can include but are not necessarily limited to: pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high speed dental equipment.

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I understand that treatment alternatives will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that for a successful result and to lessen the dangers of complication, the following conditions are essential on my part:

1. Excellent oral hygiene
2. Proper diet controls
3. Strict adherence to instructions
4. Cooperation in keeping appointments

I understand that there is no warranty or guarantee to my result and/or care, I also understand that I can, at any time, ask for and receive a full recital of all possible risk related to my treatment.

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification: who are constantly late for their appointments: who continue to excessively cancel their appointments: who fail to practice acceptable oral hygiene: or who are uncooperative with staff providing care.

Patient Signature: _____ Date: _____

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FINANCIAL POLICY AND RELEASE BENEFITS

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Feel free to ask about our fees, Financial Policy, or your responsibility.

IF YOU HAVE INSURANCE

Dental insurance is a contract between you and your insurance company. It is your responsibility to understand the extent and limits of your coverage, and to provide our staff with accurate information to process your claim efficiently (i.e. insurance company address, phone number, etc.). It is not our place to enter into disputes between you and your insurance company regarding deductibles, copayments, etc. other than to provide factual information. We do not directly participate with most Insurance programs; however, as a courtesy, we do process your claim for payment to be made directly to you. Certain conditions may apply to your financial arrangements that may require your authorization for release and assignment of benefits. Your signature below authorizes us to offer this when it applies to your situation. If we do not participate with your insurance, 100% of the total cost is requested at the time of treatment. If you are unable to pay 100%, affordable payment options are available. Our staff will help you process whatever paperwork is required. However, the ultimate responsibility lies with you for payment of any and all monies due.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT

RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Downtown Dental Care to release to your benefit program or its representative any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize, if applicable, payment to be sent to Downtown Dental Care.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED

Patient Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information as described in our notice of privacy practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

☐ I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Patient Signature: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

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HIPAA Compliance

PATIENT NAME _____

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name _____

Signature _____ **Date** _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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