We are pleased that you have selected us to provide dental care for you and your family.
Who may we thank for referring you to our office? _____

Patient Information

Date: _____ Patient's name: _____ (Last) _____ (First) _____ (Middle)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip) Cell Phone: (___) _____

Home phone: (___) _____ Social Security # _____ - _____ - _____ Driver's License # _____

Email address: _____

Birth date: ___/___/___ If patient is a minor, give parent's/guardian's name: _____

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

Name of nearest relative not living with you: _____ Relationship: _____

Complete address: _____ Phone: (___) _____

Emergency contact: _____ Phone: (___) _____

Responsible Party Information

Name: _____ (Last) _____ (First) _____ (Middle) _____ (Marital Status)

Residence: _____ (Street) _____ (City) _____ (State) _____ (Zip)

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

How long at this address? _____ Home phone: (___) _____ Work phone: (___) _____

Previous address (if less than 3 years): _____ (Street) _____ (City) _____ (State) _____ (Zip)

Social Security # _____ - _____ - _____ Birth date: ___/___/___ Relationship to patient: _____

Employer: _____ Occupation: _____ No. years employed: _____

Employer address: _____

Social Security # _____ - _____ - _____ Birth date: ___/___/___ Work phone: (___) _____

Insurance Information

Insured's name: _____ Insured's Social Security # _____ - _____ - _____

Insurance company: _____ Group No. _____

Insurance company address: _____ Phone # (___) _____

Is policy connected with your union? Yes___ No___ Name of union: _____ Local No. _____

Do you have dual coverage? Yes___ No___ If yes: Please complete the following secondary insurance information.

Insured's name: _____ Insured's Social Security # _____ - _____ - _____

Insurance company: _____ Group No. _____ Local No. _____

Insurance company address: _____ Phone # (___) _____

Insured's employer: _____ Phone # (___) _____

Oral Information

Do your gums bleed when your 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 examination _____ What was done at that time? _____

How would you describe your current dental problem? _____

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

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth _____

1. Yes/No Is your general health good? _____
   If NO, explain: _____
2. Yes/No Has there been a change in your health within the last year? _____
   If YES, explain: _____
3. Yes/No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes/No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam: _____ Reason for exam: _____
5. Yes/No Have you had problems with prior dental treatment? _____
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. Yes/No Are you in pain now: _____
   If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle yes or no for each)

Yes/No	Chest pain (angina)	Yes/No	Blood in stools	Yes/No	Frequent vomiting
Yes/No	Fainting spells	Yes/No	Diarrhea or constipation	Yes/No	Jaundice
Yes/No	Recent significant weight loss	Yes/No	Frequent urination	Yes/No	Dry mouth
Yes/No	Fever	Yes/No	Difficulty urinating	Yes/No	Excessive thirst
Yes/No	Night sweats	Yes/No	Ringing in ears	Yes/No	Difficulty swallowing
Yes/No	Persistent coughs	Yes/No	Headaches	Yes/No	Swollen ankles
Yes/No	Coughing up blood	Yes/No	Dizziness	Yes/No	Joint pain or stiffness
Yes/No	Bleeding problems	Yes/No	Blurred vision	Yes/No	Shortness of breath
Yes/No	Blood in urine	Yes/No	Bruise easily	Yes/No	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle yes or no for each)

Yes/No	Heart disease	Yes/No	AIDS/HIV	Yes/No	Psychiatric care
Yes/No	Family history of heart disease	Yes/No	Surgeries	Yes/No	Osteoporosis
Yes/No	Heart attack	Yes/No	Hospitalization	Yes/No	Thyroid disease
Yes/No	Artificial joint	Yes/No	Diabetes	Yes/No	Asthma
Yes/No	Stomach problems or ulcers	Yes/No	Family history of diabetes	Yes/No	Hepatitis
Yes/No	Heart defects	Yes/No	Tumors or cancer	Yes/No	Sexually transmitted disease
Yes/No	Heart murmurs	Yes/No	Chemotherapy	Yes/No	Herpes
Yes/No	Rheumatic fever	Yes/No	Radiation	Yes/No	Canker or cold sores
Yes/No	Skin disease	Yes/No	Arthritis, rheumatism	Yes/No	Anemia
Yes/No	Hardening of arteries	Yes/No	Emphysema or other lung disease	Yes/No	Liver disease
Yes/No	High blood pressure	Yes/No	Kidney or bladder disease	Yes/No	Eye disease
Yes/No	Seizures	Yes/No	Stroke	Yes/No	Transplants
Yes/No	Cosmetic surgery	Yes/No	Eating disorders	Yes/No	Tuberculosis

III. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle yes or no for each)

Yes/No	Aspirin	Yes/No	Valium	Yes/No	Tetracycline
Yes/No	Darvon	Yes/No	Demerol	Yes/No	Vicodin
Yes/No	Codeine	Yes/No	Penicillin	Yes/No	Percodan
Yes/No	Latex	Yes/No	Food	Yes/No	Nitrous oxide
Yes/No	Local anesthetic (Novocain or Xylocaine)	Yes/No	Erythromycin	Yes/No	Metal

_____

Patient / Guardian Signature *Date*

IV. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING? (Please circle yes or no for each)

Yes/No	Recreational Drugs	Yes/No	Tobacco in any form	Yes/No	Antibiotics
Yes/No	Over-the-counter medication	Yes/No	Alcohol	Yes/No	Supplements
Yes/No	Weight loss medication	Yes/No	Bisphosphonate (Fosamax)	Yes/No	Aspirin

Please list medications you are taking at this time: _____

V. WOMEN ONLY (Please circle yes or no for each)

Yes/No Are you or could you be pregnant? If YES, what month? _____

Yes/No Are you nursing?

Yes/No Are you taking birth control pills?

VI. ALL PATIENTS (Please circle yes or no for each)

Yes/No Do you have or have you had any other disease or medical problems NOT listed on this form?
If YES, please explain: _____

Yes/No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes/No Have you ever taken Fen-Phen? If YES, when: _____

Yes/No Is there an issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omission that I may have made in the completion of this form.

Signature of Patient (Patient or Guardian)	Date	Signature of Dentist	Date

---

MEDICAL UPDATE

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS

CHILDREN AND MINORS

If your child is scheduled for a dental appointment and is under the age of 18, a parent or guardian must be **present and in the office for the entire appointment.** If the parent or guardian leaves the office at anytime during the scheduled appointment the office will stop all scheduled treatment until the parent or guardian returns and rescheduling may be required.

REFUND POLICY

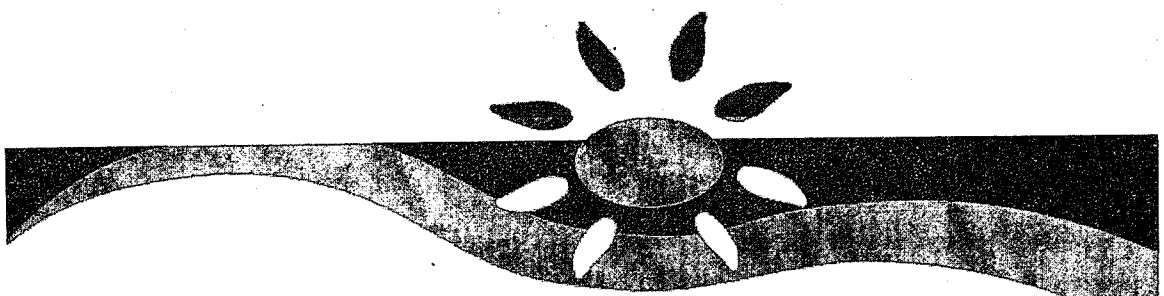
In the event you choose to terminate treatment, there will be a charge of 10% for cash patients and 15% charge for credit card and care credit holders for processing fees. Patient will also be responsible for any lab fees that were incurred. If given a discount for treatment plan and you pay in full and choose not to follow through with treatment, then the treatment that has been completed will be charged out at our UCR fees. Patient refunds take 30 business days to process.

Please understand that all dental services provided to you and your family is charged directly to the patient. We will bill your insurance for services that are performed and carry the outstanding balance for you until the claim is paid as a courtesy. When we receive payment on your dental claim or claims, any unpaid portions by the insurance will become your responsibility and we will bill your accordingly.

Our offices may close any insurance claim that goes for more than 90 days without payment and you will be responsible for the balance on the claim and will have to contact your insurance company for reimbursement.

We would like to remind patients, that just because you have insurance, it doesn't mean that they pay 100% of your fees. We will do our very best to answer any questions that you may have. Ultimately, it is the patient's responsibility to know how your policy works. All estimates to patients are just estimates. We do pride ourselves on our ability to provide you with an estimate of patient portions and insurance portions. These estimates that we provide are approximately 95% accurate.
Insurance is not a guarantee of payable benefits. A claim payment is determined once the insurance company has received a claim and it has been reviewed by your policy for eligibility based on frequency limitations, percentage of coverage, activation of policy at time of service, and overall dental decision. Thank You!!

Signature _____ Date_____



HEMET SMILES

Financial Policies

I certify that the insurance information is correct and true, and that I am eligible for dental coverage. I understand that if the information is **NOT** true or I am **NOT** eligible under the terms of my Dental Subscriber Insurance Agreement, I am liable for all charged services rendered. Also, if the information is **NOT** true, I agree to pay in full for all services received within thirty **(30) days** of receiving a bill from **HEMET SMILES.** Not all services may be covered under your particular insurance plan. Since your insurance company and coverage plan were your choice, all services not covered are your responsibility. Payments for rendered services, unpaid deductibles, and co-payments are due at time of service.

I directly assign all dental benefits to **HEMET SMILES** and understand that I am personally financially responsible for all charges whether or not paid by my insurance. I herby authorize **HEMET SMILES** to release all information necessary to secure payments of benefits. I agree that a photocopy of this agreement be as valid as the original.

I also understand that I will be charged for a broken appointment fee based on the amount of the Doctor's time put aside for my appointment. Our policy is to charge **$25 for minor treatment** (fillings, extractions, cleanings, exams, and consults) if not notified **24 hours** prior to the appointment and **$50 for major treatment** (bridges, crowns, dentures, root canal by gp and oral surgery) if not notified **48 hours** before the appointment time and **$100 for specialist** if not notified **72 hours** prior to appointment. This amount must be paid before any further care is given.

I understand that it is my responsibility as the patient to inform **HEMET SMILES** of any changes in my dental coverage prior to any appointments I may have scheduled.

Thank you for understanding our policies; please let us know if you have any questions.

Name of Subscriber_____ **Subscriber DOB**_____

Subscriber SS#_____ **Subscriber Employer**_____

Patient Name_____ **Patient DOB**_____

Insurance Plan_____ **Plan/Group #**_____

Patient Signature_____ **Date**_____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize _____ to use and/or disclose the
[Name of Health Care Provider]
protected health information described below to _____.
[Name of Individual]

2. Authorization for Release of Information. Covering the period of health care from

☐ _____ to _____ **OR** ☐ all past, present and future periods:

a. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. ☐ I hereby **authorize the release of my complete health record with the exception of the following information:**

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

3. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until _____, at which time this authorization expires.
[Date or Event]

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

687955.03