PATIENT INFORMATION

Date: _____ Phone Number: _____ Alternate Number: _____

Patient Name: _____ SSN#_____

Patient Birth Date: _____ Sex: M F Patient Marital Status: Single Married Minor Other

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

Responsible Party: _____ Relationship: _____

Reason for Today's Visit: _____ Pharmacy name & Number _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental care you will receive.

Are you under a physician's care now? O Yes O No If yes, please explain: _____
Have you ever been hospitalized or had a major surgery? O Yes O No If yes, please explain: _____
Have you ever had a serious head or neck injury? O Yes O No If yes, please explain: _____
Are you taking any medications, pills, or drugs? O Yes O No If yes, please explain: _____
Do you use tobacco or consume alcohol? O Yes O No If yes, how often: _____

Women: Are you: Pregnant/Trying to get pregnant? O YES O NO Taking oral contraceptives? O YES O NO Nursing? O YES O NO

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex
O Sulfa Drugs O Other If yes, please explain:_____
Do you have, or have you had, any of the following?

AIDS/HIV Positive O Yes O No	Cortisone Medicine O Yes O No	Hemophilia O Yes O No	Radiation Treatment O Yes O No
Alzheimer's Disease O Yes O No	Diabetes O Yes O No	Hepatitis A O Yes O No	Recent Weight Loss O Yes O No
Anaphylaxis O Yes O No	Drug Addiction O Yes O No	Hepatitis B or C O Yes O No	Renal Dialysis O Yes O No
Anemia O Yes O No	Easily Winded O Yes O No	Herpes O Yes O No	Rheumatic Fever O Yes O No
Angina O Yes O No	Emphysema O Yes O No	High Blood Pressure O Yes O No	Rheumatism O Yes O No
Arthritis/Gout O Yes O No	Epilepsy/Seizures O Yes O No	High Cholesterol O Yes O No	Scarlet Fever O Yes O No
Artificial Heart Valve O Yes O No	Excessive Bleeding O Yes O No	Hives/Rash O Yes O No	Shingles O Yes O No
Artificial Joint O Yes O No	Excessive Thirst O Yes O No	Hypoglycemia O Yes O No	Sickle Cell Disease O Yes O No
Asthma O Yes O No	Fainting/Dizziness O Yes O No	Irregular Heartbeat O Yes O No	Sinus Trouble O Yes O No
Blood Disease O Yes O No	Frequent Cough O Yes O No	Kidney Problems O Yes O No	Spina Bifida O Yes O No
Blood Transfusion O Yes O No	Frequent Diarrhea O Yes O No	Leukemia O Yes O No	Stomach Disease O Yes O No
Breathing Problem O Yes O No	Frequent Headaches O Yes O No	Liver Disease O Yes O No	Stroke O Yes O No
Bruise Easily O Yes O No	Genital Herpes O Yes O No	Low Blood Pressure O Yes O No	Swelling of Limbs O Yes O No
Cancer O Yes O No	Glaucoma O Yes O No	Lung Disease O Yes O No	Thyroid Disease O Yes O No
Chemotherapy O Yes O No	Hay Fever O Yes O No	Mitral Valve Prolapse O Yes O No	Tonsillitis O Yes O No
Chest Pains O Yes O No	Heart Attack/Failure O Yes O No	Osteoporosis O Yes O No	Tuberculosis O Yes O No
Cold Sores/ Blisters O Yes O No	Heart Murmur O Yes O No	Pain in Jaw Joints O Yes O No	Tumors or Growths O Yes O No
Congenital Heart Disorder O Yes O No	Heart Pacemaker O Yes O No	Parathyroid Disease O Yes O No	Ulcers O Yes O No
Convulsions O Yes O No	Heart Trouble/Disease O Yes O No	Psychiatric Care O Yes O No	Venereal Disease O Yes O No
			Yellow Jaundice O Yes O No

Have you ever had any serious illness not listed above? O Yes O No _____
Comments: _____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PRIVACY PRACTICE (HIPPA) PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we will honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this consent in writing signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices that may be reviewed upon request.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their health information, but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this consent.

In general, the HIPPA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that the communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure made pursuant to an authorization request by the individual. Please initial acknowledging that you are aware of the HIPPA privacy rule above.

Initial _____

Patient or Guardian Signature _____Date:_____

Witness: _____ Date: _____

DENTAL HISTORY

Former Dentist: _____City/State_____
Date of the last dental x-rays _____

Place or mark on “yes” or “not” to indicate if you have had any of the following:

- Bad breath Yes_____ No _____
- Bleeding gums Yes _____ No _____
- Blister on lips or mouth Yes _____ No ____
- Burning sensation on tongue Yes _____ No _____
- Chew on one side of the mouth Yes_____ No _____
- Cigarette, pipe, or cigar smoking Yes_____ No _____
- Clicking or pumping jaw Yes_____ No _____
- Dry mouth Yes_____ No _____
- Fingernail biting Yes_____ No _____
- Food collection between the teeth Yes_____ No _____
- Foreign objects Yes _____ No _____
- Grinding teeth Yes_____ No _____
- Gums swollen or tender Yes_____ No _____
- Jaw pain or tiredness Yes_____ No _____
- Lip or check biting Yes_____ No _____
- Loose teeth or broken fillings Yes_____ No _____
- Mouth breathing Yes_____ No _____
- Mouth pain, brushing Yes_____ No _____
- Orthodontic treatment Yes _____ No _____
- Pain around ear Yes _____ No _____
- Periodontal treatment Yes _____ No _____
- Sensitivity to cool Yes_____ No _____
- Sensitivity to heat Yes _____ No _____
- Sensitivity to sweets Yes _____ No _____
- Sensitivity when biting Yes_____ No _____
- Sores or growths in your mouth Yes _____ No _____
- How often do you floss? _____
- How often do you brush? _____

FACTS ABOUT DENTAL INSURANCE

Fact #1: Your dental insurance is based upon a contract between your employer and the insurance company. Should questions arise regarding your dental insurance benefits, it is best for you to contact your employer or the insurance company directly.

Fact #2: Dental insurance benefits differ greatly from traditional medical health insurance benefits and can vary quite a bit from plan to plan. When dental insurance plans first appeared in the early 1970's most plans had a yearly maximum of $1000. Today, some 30+ years later, most plans still have an annual maximum of $1000. That the premiums remained the same, allowing for a conservative yearly rate of inflation, your yearly plan maximums should be in excess of $4500 today. Your premiums have increased, but your benefits have not. Therefore, dental insurance was never set-up to cover your services 100%; it is only an aid.

Fact #3: You may receive a notification from your insurance company stating that dental fees are "higher than usual and customary." Insurance companies never reveal how they determine "usual, customary and reasonable"(UCR) fees. A recent survey done in the state of Washington found at least eight different UCR fee schedules for one zip code in the Seattle area. The fees are somehow determined by taking "a percentage" of an average fee for a particular procedure in a geographic area. Average has been defined as "the worst of the best" or "the best of the worst." We do not provide average dentistry nor do we charge average fees.

Fact #4: Many plans tell their participants that they will be covered "up to 80% or up to 100%," but do not clearly specify p lan fee schedule allowances, annual maximums, or limitations. It is more realistic to expect dental insurance to cover 35 to 50 o f major services. Remember, the amount a plan pays is determined by how much the employer paid for the plan. You get back only what your employer puts in, less the profits of the insurance company.

Fact #5: Many routine dental services are not covered by insurance companies. This does not mean they aren't necessary or appropriate, just not covered.

We feel that dental insurance can be a great benefit for many patients and want you to know we will do everything in our power to insure that you get every benefit dollar you are entitled to. However, the treatment we recommend and the fees we charge will always be based on your individual need, not your insurance coverage. The ultimate decision as to what will be done and how fast we proceed will always be made by you. Based on your decision, we will discuss the total cost of treatment and what assistance you can expect from your dental insurance. 'All arrangements are strictly between you and our office. The full responsibility for payment of services rendered will always be with you.

Welcome

Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally. Our philosophy of care governs everything we do for you. It consists of the following key elements:

- ✓ We are truly caring about our patients and want you to feel very comfortable with our entire staff.
- ✓ We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.
- ✓ We strive to be thorough in everything we do, taking the time to be the best we can be.
- ✓ We are esthetics oriented, helping you look your best, while maintaining optimum comfort, function and health.

At your first visit, we will take the time to get to know you (and you, us) and discuss your dental needs and desires. We will perform a comprehensive dental evaluation and gather information to make a customized plan for you. This will take approximately between 30-60 minutes.
Sincerely, MEGA DENTAL

Cancellation Policy/No Show Policy

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Due to the large block of time needed for treatments, last minute cancellations can cause problems and added expenses for the office.

***If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollars ($50) fee. Same-day cancelations will also cause a charge of $50 fee; this will not be covered by your insurance company.**

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.

***If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.**

3. Account balances

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ ____/____/____

Print Name Patient **Signature Patient/Guardian** **Date**

What Are the Benefits, Side Effects, and Recommendations for Fluoride Treatment?

Fluoride is a natural mineral that builds strong teeth and prevents cavities. It's been an essential oral health treatment for decades. Fluoride supports healthy tooth enamel and fights the bacteria that harm teeth and gums. Tooth enamel is the outer protective layer of each tooth.

Cavities occur when bacteria build up on teeth and gums and form a sticky layer of plaque. Plaque produces an acid that erodes teeth and gum tissue. If the plaque breaks down the enamel layer, bacteria can infect and harm the nerves and blood at the core of the tooth.

Fluoride works by restoring minerals to tooth surfaces where bacteria may have eroded the enamel. It can also inhibit the growth of harmful oral bacteria and further prevent cavities.

"Fluoride cannot remove decay but, while creating a stronger outer surface to your teeth, it can help stop the decay from penetrating into the deeper parts of teeth,"

What happens during a professional fluoride treatment?

Dentists provide professional fluoride treatments in the form of a highly concentrated rinse, foam, gel, or varnish. The treatment may be applied with a swab, brush, tray, or mouthwash.

They only take a few minutes to apply. You may be asked to avoid eating or drinking for 30 minutes after the treatment so the fluoride can fully absorb.

How much does a fluoride treatment cost?

Insurance usually covers fluoride treatments at the dentist for children. Adults, however, may pay $10 to $30 out of pocket. Always ask your dentist about costs before treatment.

How much fluoride do you need?

The American Dental Association (ADA) recommends a professional fluoride treatment at your dentist's office every 3, 6, or 12 months, depending on your oral health. If you're at high risk for cavities, your dentist may also prescribe a special fluoride rinse or gel to use regularly at home.

Are there side effects to fluoride?

Like any medication, too much fluoride can cause negative complications. You can get too much fluoride by accidentally overdosing or by being prescribed a dose that's too high**. Fluoride poisoning is very rare today**, though chronic overexposure may harm developing bones and teeth in small children. Many children's toothpastes don't include fluoride.

Please let us know if you are interested in Fluoride treatment

_____YES _____ NO

Name_____ Date_____

MEDIA RELEASE FORM

I, _____, grant permission to _____, hereinafter known as the "Media" to use my image (photographs and/or video) for use in Media publications including:

(Check All That Apply)

☐ Videos ☐ Email Blasts ☐ Recruiting Brochures ☐ Newsletters ☐ Magazines ☐ General Publications ☐ Website and/or Affiliates ☐ Pictures
☐ Other: _____

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Please **initial** the paragraph below which is applicable to your present situation:

_____ - I am 20 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

_____ - I am the parent or legal guardian of the below named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

Signature: _____ Date: _____

Name (please print): _____

Address: _____

Signature of parent or legal guardian: _____
(if under 20 years of age)