SC DENTAL CARE
22972 Moulton Parkway, Suite 106
Laguna Hills, CA 92653

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

This form acknowledges your receipt of the HIPAA Notice of Privacy Practices, or our good faith effort to obtain that acknowledgment.

Patient's Name: ______________________________
(Please print)

Patient/Parent's Signature: ______________________ Date: __________

Patient Representative's Signature: ______________________ Date: __________

FOR OFFICE USE ONLY BELOW THIS LINE

PLEASE SPECIFY THE REASON THE PATIENT CHOSE NOT TO SIGN THE ACKNOWLEDGMENT OF RECEIPT OF THE HIPAA NOTICE OF PRIVACY PRACTICES:

- ☐ **Patient/Parent or Legal Representative received the HIPAA Notice of Privacy Practices but refused to sign the Acknowledgment of Receipt.**
- ☐ **Patient/Parent or Legal Representative unavailable to acknowledge receipt of the HIPAA Notice of Privacy Practices.**

Staff Signature: ______________________ Date: __________

Rev. 5/21/03

Abuse or Neglect: We may disclose your protected 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 protected 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 protected health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials protected health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose protected health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

PATIENT RIGHTS:

Access: You have the right to look at or obtain copies of your protected 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 practically do so. You must make your request in writing. 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 $10.00 without x-rays, and $20.00 if x-rays are requested. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected 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 protected health information for purposes other than: treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not prior to 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 protected health information. We are not required to agree to these additional restrictions, however, 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 protected 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 of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and 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 protected health information, or in response to a request you made to amend or restrict the use or disclosure of your protected 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 may also 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.

Privacy Contact: Heather Foster, Office Administrator — Telephone: (949) 770-3010

Address: South Coast Dental Specialties — 30190 Town Center Drive, Suite B, Laguna Niguel, CA 92677

May 1, 2003

SC DENTAL CARE
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED 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 PROTECTED HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until replaced. 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 protected health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your protected health information to a physician or other healthcare provider providing treatment to you.

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

Healthcare Operations: Our dental facility employs an open system of delivering dental care. We will make every reasonable attempt to avoid accidental disclosure of your protected health information. Should you have any concerns, please advise us and we will attempt to accommodate you. We may use or disclose, as needed, your protected health information in order to support our business activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign in. We may call you by name in the reception room when the doctor is ready to see you, and he may have a copy of that day's schedule with your name on it in his operatory. We may use or disclose your protected health information, as needed to contact you by phone, e-mail, or mail, to confirm your dental appointment. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, etc.) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to send you a newsletter or information regarding other services we might offer. We may also send you information about products or services we feel might be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Your Authorization: We will obtain your written authorization should we need to use or disclose your protected health information outside of our third party associates.

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

Persons Involved in Your Care: We may use or disclose your protected health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, your location, your general condition, or your death. If you are present, prior to use or disclosure of your protected health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose your protected health information based on a determination using our professional judgment, disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of your protected health information.

Marketing Health-Related Services: We will not use your protected health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your protected health information when we are required to do so by law.

Please take a moment to tell us about your smile so that we may better serve your individual needs

WHEN I SEE A PICTURE OF MYSELF, THE FIRST THING I NOTICE ABOUT MY SMILE IS:

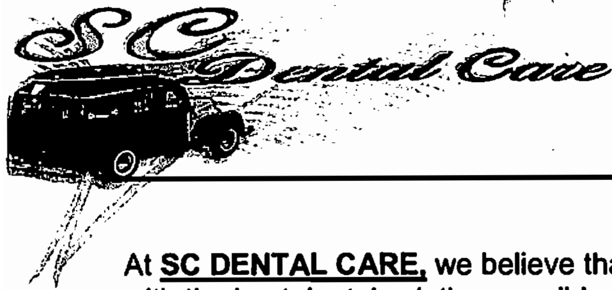
____

SOME THINGS THAT I CONSIDER ATTRACTIVE IN OTHER PEOPLE'S SMILES ARE:

____

**Please "√" the statements below that apply to you.

- o I wish my teeth were straighter.
- o I wish I had a broader smile.
- o I think some of my teeth are too small.
- o I think some of my teeth are too large.
- o I wish my teeth were whiter with regard to their color
- o I think my gums show too much when I smile.
- o I think my smile shows too much space between some of my teeth.
- o Because I am not totally pleased with my teeth, I sometimes hesitate to smile.
- o I feel as though I don't really know all of the options available to me for enhancing my smile.
- o Concerns over what the end result might look like have been a factor in my not having aesthetic dentistry in my mouth.
- o Concerns over fees have prevented me from taking advantage of some of the available options to enhance my smile.
- o I feel as though I could do a better job protecting the health of my teeth and gums, and therefore, the longevity of my smile.



INSURANCE AND FINANCIAL POLICY

At **SC DENTAL CARE,** we believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients; some have benefits, while others do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know...

Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

We currently accept all private care insurance plans and most managed care plans. This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We **estimate** your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your **exact** insurance benefit we will be happy to file a *Pre-treatment Authorization* with your insurance company prior to treatment. This does delay treatment, but will give you the exact out-of pocket figures you may require.

We bill your insurance as a courtesy. If your insurance does not pay within 90 days, SC DENTAL CARE reserves the right to request payment in full for services from you, and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not and cannot be, a part of that legal contact. Ultimately, you are responsible for all charges incurred in our office.

SC DENTAL CARE does require payment in full for your portion **at the time of service**. We accept MasterCard, Visa, American Express, Discover, Cash and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with Care Credit ® who offers a 12-month *same as cash* or longer terms with an interest-bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of our Patient Service staff for an application.

Broken Appointments: A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointment, we require at least a 24-hour notice to avoid a $35.00 cancellation fee (emergencies are an exception).

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you have always wanted. If there is anything we can do to make your visits here more pleasant, please do not hesitate to ask one of our staff members.

Print Name: ____

Signature: ______________________________ Date: ______________

Cosmetic, Implant & General Dentistry
22972 Moulton Pkwy., Suite 106 - Laguna Hills, Ca 92653 - Tel. 949.770.3010 - Fax 949.837-5410

❹ CROWNS, BRIDGES, AND OTHER DENTAL CASTINGS

DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR

❺ FILLINGS

TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR

❻ ENDODONTIC TREATMENT (ROOT CANAL)

TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR

❼ REMOVAL OF TEETH

TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR

❽ OTHER PROCEDURES

DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	IO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR

SC Dental Care

DENTIST

PATIENT

❶ WORK TO BE DONE

I understand that I am having the following work done: ○ Fillings________ ○ Crowns________ ○ Extractions________ ○ Dentures________ ○ Impacted Teeth Removed________ ○ Root Canals________ ○ Periodontal Treatment________ ○ Other________

❷ DRUGS, MEDICATIONS, AND X-RAYS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. X-Rays are taken by qualified personnel. Exposure to X-Ray radiation (minimal). X-Ray pictures remain the property of this office. Full mouth series of X-Rays may be necessary to aid in diagnosing future dental treatment.

❸ CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions that were not discovered during examination but were found while working on the teeth. For example, root canal therapy may be discovered to be needed during routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

❹ CROWNS, BRIDGES, AND OTHER DENTAL CASTINGS

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

❺ FILLINGS

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

❻ ENDODONTIC TREATMENT (ROOT CANAL)

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 effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented 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 despite all effort to save it.

❼ REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth___________ and any others necessary for reasons in paragraph #3. 1 understand removing teeth does not always remove all 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, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue, or fractured jaw. I understand removal of teeth can result in paraesthesia that can last permanently or for an indefinite period of time, and that paraesthesia numbness is a possible risk of injection/extraction. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

❽ PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

❾ DENTURES

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

❿ DENTAL MATERIALS FACT SHEET ACKNOWLEDGMENT

SC Dental Care made the Dental Materials Fact Sheet available to me to read in the office and/or take home . I acknowledgement that this was made readily available for me and I have chosen to or not to read this material.

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 and authorized. I understand that no other Dentist is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I understand that this practice provides space, equipment, support personnel and administrative services to allow each dentist to focus on patient care. The individual dentists practicing at this practice are not agents or employees of this practice. Each of them exercises independent professional judgement in the nature and manner of dental care and treatment provided. I ACKNOWLEDGE THAT I AM AWARE THAT ALL OF THE DENTISTS ARE NOT EMPLOYEE AGENTS OF THIS DENTAL MANAGEMENT COMPANY.

X______________________________ DATE______________ X______________________________ WITNESS______________

SIGNATURE OF PATIENT *SIGNATURE OF DOCTOR*

X______________________________ DATE______________ X______________________________ DATE______________

PLEASE PRINT NAME, IF A MINOR, PLEASE PRINT THE MINORS NAME *SIGNATURE* ☐ *PARENT / GUARDIAN* ☐ *SPOUSE*

If the patient is under the age of 18 years old, please have a parent or legal guardian sign this form.

MEDICAL HISTORY

1. Are you in good health? . . . . Yes ___ No ___
2. Date of last physical examination ___________
3. Are you now under the care of a physician? . . . . Yes ___ No ___
   If so, what is the condition being treated? ___________
4. Have you ever had any serious illness or operation? . . . . Yes ___ No ___
   If so, what illness or operation? ___________
5. Have you ever been hospitalized? . . . . Yes ___ No ___
   If so, what was the problem ___________
6. Are you taking any medication? .Yes ___ No ___ or any recreational drugs (marijuana, cocaine, etc.)? Yes ___ No ___
   If so, what? ___________ What dosage? ___________
7. Are you sensitive or allergic to any drugs? Penicillin O Y O N Tetracycline O Y O N Aspirin O Y O N Codeine O Y O N
   Other O Y O N If Other, what drugs? ___________
8. Do you have or have you had any of the following: (please check known conditions - Y box for YES, N box for NO)

Y	N		Y	N		Y	N		Y	N		Y	N		Y	N	
O	O	Anemia	O	O	Cold Sores	O	O	Sinus Trouble	O	O	Blood Transfusion	O	O	Pain in Jaw Joints	O	O	X-Ray or Cobalt Treatment
O	O	Herpes	O	O	Hemophilia	O	O	Blood Disease	O	O	Joint Replacement	O	O	Respiratory Disease	O	O	Fainting Spells or Seizures
O	O	Stroke	O	O	Rheumatism	O	O	Drug Addiction	O	O	Nervous Disorders	O	O	Sickle Cell Disease	O	O	Chemotherapy (Cancer, Leukemia)
O	O	Ulcers	O	O	Bruise Easily	O	O	Kidney Disease	O	O	Tumors or Growths	O	O	Tuberculosis (T.B.)	O	O	Radiation Treatment of any kind
O	O	Diabetes	O	O	Head Injuries	O	O	Stomach Injuries	O	O	Allergies or Hives	O	O	Epilepsy or Seizures	O	O	Hepatitis or Jaundice
O	O	Glaucoma	O	O	Heart Failure	O	O	Angina Pectoris	O	O	Cortisone Medicine	O	O	Psychiatric Treatment	O	O	Venereal Disease (Syphilis, Gonorrhea)
O	O	Arthritis	O	O	Liver Disease	O	O	Mental Disorder	O	O	Excessive Bleeding	O	O	Congenital Heart Lesions	O	O	Acquired Immune Deficiency Syndrome (AIDS)
O	O	Emphysema	O	O	Scarlet Fever	O	O	Thyroid Disease	O	O	Asthma	O	O	Difficulty in Swallowing	O	O	TMJ (Temporomandibular joint)
O	O	Hay Fever	O	O	Chicken Pox	O	O	Cerebral Palsy	O	O	High Blood Pressure	O	O	Heart Ailments or Attacks	O	O	Artificial Prosthesis
O	O	Tonsillitis	O	O	Heart Murmur	O	O	Latex Allergy	O	O	Phen-Fen Medication	O	O	Mitral Valve Prolapse	O	O	Rheumatic Fever
			O	O	AIDS Related Complex							O	O	Other			

If yes, has your physician ever told you that you must take preventative antibiotics for your dental treatment? Yes ___ No ___

9. Do you wear a cardiac pacemaker, or have you had heart surgery? . . . . Yes ___ No ___
10. Do you have any disease, condition or problem not listed that you think we should know about? . . . . Yes ___ No ___
    If so, what? ___________
11. Do you smoke? If yes, how much? ______ per day . . . . Yes ___ No ___
12. (Women) Are you pregnant? If so, how many months ____ . . . . Yes ___ No ___
13. (Women) Do you have any problems associated with your menstrual period? . . . . Yes ___ No ___
14. (Women) Do you take birth control pills? . . . . Yes ___ No ___

DENTAL HISTORY

Have you ever had any unfavorable reaction from a local anesthetic . . . . Yes ___ No ___
Have you had any serious trouble associated with any previous dental treatment? . . . . Yes ___ No ___
If so, explain ___________
Do your gums bleed when you brush? Yes ___ No ___ Are your teeth sensitive to heat or cold . . .Yes ___ No ___
Are your teeth sensitive to pressure? .Yes ___ No ___ Are your teeth sensitive to 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 examination or treatment ___________
How do you feel about the appearance of your teeth? ___________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will without fail, inform the doctor at my next appointment.

Date ___________ Signature ___________

Year2 Changes in Health ___________ Date ___________ Signature ___________

Year3 Changes in Health ___________ Date ___________ Signature ___________

Health Questions MUST be updated every year.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment on this patient. I have been informed of all complications of the procedures, anesthetics and/or drugs.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

All service are rendered and accepted under terms and conditions printed on the reverse hereof

Signed: ___________ Date: ___________ Relationship to the patient: ___________

Authorization must be signed by the patient, or : nearest relative in the case of a minor or when atient is physically or mentally incompetent.

SC Dental Care

PATIENT INFORMATION/QUESTIONNAIRE

DATE ______________

WELCOME! Thank you for selecting SC Dental. This information is necessary for our files and will be considered CONFIDENTIAL.

PATIENT INFORMATION

Patient's Name ______________ (LAST) ______________ (FIRST) ______________ (INITIAL) Social Security # ______________

Nickname ______________ Sex ○ M ○ F Age______ Birthdate ______________ DL# ______________

If patient is a minor, give name of parent or legal guardian ______________ Relationship ______________

Patient's Address ______________ (STREET) ______________ (CITY) ______________ (ZIP) Residence Phone (_____) ______________

E-mail Address ______________

Patient is: ○ MARRIED ○ SINGLE ○ SEPARATED ○ WIDOW ○ MINOR

Employed by ______________ How long? ______________ Occupation ______________

Business Address ______________ (STREET) ______________ (CITY) ______________ (ZIP) Business Phone (_____) ______________

Spouse's Name ______________ Birthdate ______________ Social Security # ______________

Employed by ______________ How long? ______________ Occupation ______________

Business Address ______________ (STREET) ______________ (CITY) ______________ (ZIP) Business Phone (_____) ______________

Name of nearest relative not living with you ______________ Relationship ______________

Complete Address ______________ (STREET) ______________ (CITY) ______________ (ZIP) Residence Phone (_____) ______________

Name of Physician ______________ (ADDRESS) ______________ (CITY) ______________ (TELEPHONE)

Former Dentist ______________ (ADDRESS) ______________ (CITY) ______________ (TELEPHONE)

Purpose of Appointment ______________ Whom may I thank for referring you? ______________

FINANCIAL INFORMATION

Person responsible for this account ______________ Relationship ______________

Address (if different from above) ______________ (ADDRESS) ______________ (CITY) ______________ (TELEPHONE)

PREFERENCE OF PAYMENT: ○ Cash on day of treatment ○ Bank Charge Card ______________ (EXP.)

Name of Insurance company ______________ ______________ (GROUP NO.) ______________ (PHONE NUMBER)

______________ (NAME OF INSURER) ______________ (BIRTHDATE) ______________ (RELATIONSHIP) ______________ (SOCIAL SECURITY NO.)

DO YOU HAVE ADDITIONAL INSURANCE? ○ ***YES*** ○ ***NO*** ***IF YES, PLEASE COMPLETE THE FOLLOWING:***

Name of insurance company ______________ (GROUP NO.) ______________ (PHONE NUMBER)

______________ (NAME OF INSURER) ______________ (BIRTHDATE) ______________ (RELATIONSHIP) ______________ (SOCIAL SECURITY NO.)

TERMS AND CONDITIONS: As a condition of treatment by this office, I understand arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are preformed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

ASSIGNMENT OF INSURANCE: I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1 1/2% per month (18% per annum) (but in no event more that the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination. In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff. I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree the a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I understand that this practice provides space, equipment, support personnel and administrative services to allow each dentist to focus on patient care. The individual dentists practicing at this practice are not agents or employees of this practice. Each of them exercises independent professional judgement in the nature and manner of dental care and treatment provided. I ACKNOWLEDGE THAT I AM AWARE THAT ALL OF THE DENTISTS ARE NOT EMPLOYEE AGENTS OF THIS DENTAL MANAGEMENT COMPANY.

I have read the above conditions of treatment and agree to their content:

X ______________________________ ______________
SIGNATURE OF PATIENT *DATE*