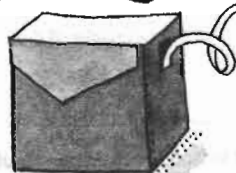


WELCOME



BRUSH

FLOSS

SMILE

PATIENT INFORMATION

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS/HIC/Patient ID# _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Sex: Female Male Birthdate _____ E-mail _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Do you prefer to receive calls at: Home Work Cell No Preference

Married Widowed Single Minor Separated Divorced Partner for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work Phone (_____) _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone (_____) _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone (_____) _____

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

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 dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you

- Pregnant/Trying to get pregnant? Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | | |
|-------------------------------------------------|----------------------------------------------------|------------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 _____

Payment for Services

Patient Name _____

Our mission is to deliver high quality, cost-effective dental care to our patients. Following your diagnosis, the doctor will advise you of his recommendation for treatment. Our staff is here to help you with your insurance questions; however it is the patient's responsibility to know their coverage and limitations. Actual benefits are determined by your insurance company at time of service. We will discuss with you the estimated cost of today's and future treatments.

Payments for services are due at the time of treatment. If you have dental insurance, we will be happy to submit your claim for you. Your estimated out-of-pocket expense for all procedures is due at the time treatment is initiated.

We are sensitive to the fact that some patients may not be able to pay in full for their treatment; therefore, we do offer several alternative payment programs for your convenience.

1. Check or Cash – 5% discount
2. MasterCard, Visa, or Discover – NO discount
3. Dental Fee plan – Terms up to 60 months. Low fixed rates, no prepayment penalty, Interest free options available.
4. Medical Bureau – Terms up to 12 months. INTEREST FREE, with no service charge.

PLEASE INDICATE YOUR CHOICE OF PAYMENT BELOW:

- Cash or Check
 MasterCard, Visa, or Discover
 Dental Fee Plan*
 Medical Bureau*

*SUBJECT TO APPROVAL

24 HOURS NOTICE IS REQUIRED FOR CHANGING APPOINTMENTS. A BROKEN APPOINTMENT FEE OF \$25.00 WILL BE APPLIED WITH LESS THAN 24 HOURS NOTICE.

X _____

Signature of Patient/Responsible Party

Date _____

Over Please

ALCOMA DENTAL ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Alcoma Dental Associates to use and disclose health/dental information about you for treatment, payment, and health/dental care operations purposes.

Notice of Privacy Practices: Alcoma Dental Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health/dental information and how you can access your protected health/dental information and exercise other rights concerning your protected health/dental information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health/dental information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Acknowledgement and Consent

I have read the Notice of Privacy Practices for Alcoma Dental Associates. Alcoma Dental Associates is authorized to use and disclose health/dental information about (patient name) _____ for treatment, payment, and healthcare operation purposes consistent with its Notice of Privacy Practices, I understand by signing this form, I will consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. This office will continue to use my health information in some of these ways: by calling me by my first name from your waiting room, by posting pictures of children in your "no cavities club", by mailing me reminder appointment cards with reason for visit, by reminding me of any pre-treatment medication if necessary, and by calling to confirm appointments, and by making my chart available for review by consultants or auditors as described in our Notice of Privacy Practices.

Patient or personal representative's signature

Date

Name of personal representative

Relationship to Patient
(Or other authority)