AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION FORM

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, insurance providers and primary care doctors, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below.

Authorization to Speak with Family/Friend (including spouses)

I give the following named person(s) authorization to take messages or speak with the office of Designer Dental Services on my behalf regarding (please check all items authorized):

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐ Other

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments ☐ Financial ☐ Dental Treatment ☐ Insurance ☐ Other

I understand my express consent is required to release my health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record, and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed below.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Notice of Privacy Practices

Federal & State laws require Designer Dental Services to maintain the privacy of all patient healthcare information. Furthermore, we are required by law to provide all parents or legal guardians with this notice reviewing our privacy practices, our legal obligations, and your rights in regard to your child's healthcare information. Designer Dental Services must follow the privacy practices as described within this notice while this policy is in effect. This notice takes effect on February 1st, 2008 and will remain in effect until replaced, amended, or eliminated.

Designer Dental Services reserves the right to change these privacy practices and the terms of this notice at any time provided such applicable laws permit such changes. We reserve the right to make any needed changes to our privacy practices and these new terms will be effective for all health information that we maintain, including health information we create or receive before such made changes. Before we make any significant changes to our privacy practices, we will change this notice and make new notice available upon request.

Parent or legal guardians may request a copy of this notice, at any time. For additional information about our privacy practices or to review our company's Health Insurance Portability & Accountability Act (HIPAA) Manual, please contact our office at any time.

USES & DISCLOSURES OF HEALTHCARE INFORMATION

Designer Dental Services will use and disclose patient healthcare information during your treatment, while obtaining payment from insurance companies and during general healthcare operations. For example:

Treatment. Designer Dental Services may use your health information during direct treatment or by disclosing such information to other dentists, physicians or healthcare providers who may provide specialized treatment for you.

Payment. We may also use and disclose your health information to obtain payment for services rendered. We may disclose your healthcare information to another healthcare provider or entity that is also subject to these same federal & state privacy rules and regulations for payment activities.

Healthcare Operations. We may use and disclose your healthcare information during our routine healthcare operations. Healthcare operations may include quality assessments and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities. We may disclose your healthcare information to another healthcare provider or organization that is subject to the same federal & state privacy rules and regulations and that has a relationship with you during the support of healthcare operations. We may disclose your information to help such organizations conduct quality assessment and improvement activities, review the competence or qualifications of healthcare professionals, or detect or prevent healthcare fraud or abuse.

On Your Authorization. You may give Designer Dental Services written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any issues or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your healthcare information for any reason except those described within this notice.

To Your Family & Friends. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for previously performed healthcare services. Before we disclose your health to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event you are incapacitated and cannot make a decision for yourself, or in the event of an emergency, we will disclose your medical information based on our professional judgment of practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical/ dental supplies, radiographs or other similar forms including health information. We may also use or disclose information about you to notify or assist in notifying a person involved in his/her care.

Appointment Reminders. Designer Dental Services may use or disclose your healthcare information to provide you and your family with appointment reminders. (Such as: telephone calls, voice messages, postcards, or letters)

Disaster Relief. We may use or disclose your healthcare information, as authorized by federal or state law for the following purposes deemed to be in the public's best interest or benefit:

- As required by law

• For public health activities, including disease and vital statistic reporting, reporting child abuse or neglect, FDA oversight and to employer's regarding work-related illness or injury.
• To health oversight agencies
• In response to court and administrative orders and lawful processes
• To law enforcement officials pursuant to subpoena and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and for purposes of identifying or locating a suspect or other persons.
• To coroners, medical examiners and funeral directors
• To an organ procurement organization
• To avert serious threat to health or safety
• In connection with certain research activities
• To the military and to federal officials for lawful intelligence, counterintelligence and national security activities
• To correctional institutions regarding inmates
• As authorized by state worker's compensation laws

PATIENTor PARENT/LEGAL GUARDIANRIGHTS

Access. You have theright to look at or receive a copy of your health information, with limited expectations. You may request that we provide a copy informat other than photocopies. Wewill usetheformat you request unless wecannot practically do so. You must make all requests in writing to obtain access to your child's healthcare information. You may request access by sending us a letter. If you request a copy, wewill chargeyou a reasonablefee, which may includelabor, copying costsand postage. If you request an alternative format, we will charge a cost-based feefor providingyour health information inthat format. If you prefer, wemay, but arenot required to, preparea summary or an explanation ofyourhealth information for a fee.

Disclosure Accounting. You havetherightto receive a list of instances inwhich Designer Dental Services or any business associates disclosed your
health information overthe past year (but not prior to June 24th2010). That list will not include disclosures for treatment, payment, healthcare operations, as authorized byyouandcertainactivities. If you requestthisaccountingmorethanonceina 12 month period, we may charge you a reasonable, cost-based feeforrespondingto these additional requests.

Restriction. You have the right to request that we place additional restrictions on the use or disclosure of your healthcare information. We are not required to agree with such additional restrictions, but if we do, we will abide by our agreement (except in the event of an emergency). Any agreement we make to a request for additional restrictions must be in writing and signed by our privacy officer. Your request is not binding unless our agreement is in writing.

Alternative Communication. You havetheright to request that we communicatewithyouabout yourhealth information byan alternative means or at an alternative location. You must makeyourrequestinwriting. You must specify in yourrequestthealternative means or location and satisfactory explanation how you will handle payment under the alternative means or location yourequest.

Amendment. You havetherightto request that we amendyourhealthcareinformation. Yourrequestmust beinwritingandshould explain why you arerequestingthisamendment. Wemaydeny your request under certain circumstances.

QUESTIONS OR COMPLAINTS

If you needadditional information regarding our office's Privacy Practices & Regulations or have specific questions or concerns, please feel freeto contact us. Furthermore, if you believethat:

- We may have violated your privacy rights
- We made a decision about access to your health information incorrectly
- Our response to a previous request to amend or restrict the use or disclosure of your information was incorrect
- We should communicate with you by alternative means or an alternative location

You may submit a written complaint with our privacy officer or directly to the US Department of Health & Human Services. We will provide you with these addresses to file your complaint, upon request. We support your right to the privacy of your child's health information. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health & Human Services.

I understand thecontents of theprevious notice concerning theprivacy of my confidential healthcare information. I dohereby provide consent for the standarduseofsuch information andunderstandthattheseprovisionsprohibit Designer Dental Services from selling or transferring this information to anyunauthorized locations without my priorapproval.Ihavereviewed this information and all questionshavebeen answered to my satisfaction.

_____ _____

Signature of Patient/ Parent or Guardian Date

Dental Practice Policies

Dear Patient:

Welcome to our dental office. We appreciate the opportunity to assist you with your dental care needs. Our goal is to provide you and your family with the best dental care available at an affordable cost and in an efficient and professional manner. We can only accomplish this goal with your help. With this in mind, we have listed our office policies below for your review.

_____ **Should you be unable to make your scheduled appointment we request that you notify the office at least 24 hours in advance**. We will make every effort to confirm your appointment with you; however, it is your responsibility to keep that appointment. A broken appointment fee of **$45.00 Monday-Friday and $75.00 for Saturday** may be billed to your account if you fail to notify the office within the time frame specified.

_____ Payment is due at the time of service. We accept cash, money orders, debit cards and all major credit cards as payment. For your convenience, we accept most dental insurances. As a courtesy, we will be happy to file your dental insurance claim to your insurance company on your behalf. **Insurance claims that are not paid within (60) days become the sole responsibility of the patient. If the balance on your account becomes more than (90) days past due, your account will be transferred to a collections agency and a fee of 30% of the balance will be added to your account.**

_____ We try very hard to adhere to a schedule. If you are more than 15 minutes late, we may have to reschedule you appointment. Sometimes an emergency will occur that will make us run behind. We do respect your time and will make every effort to stay as close to your appointment time as possible. We thank you for choosing our dental family and look forward to a long relationship with you.

_____ Please understand that dentistry is **not** an exact science and therefore reputable practitioners cannot properly guarantee results. No guarantee or assurance has been made by anyone regarding dental treatment that you have requested or authorized. Each dentist is an individual practitioner and is individually and solely responsible for the dental care rendered.

_____ Your original records belong to the office. You may request copies for you or others. We will provide them within five business days upon receiving a written request from you. There will be a fee to duplicate your chart.

_____ The patient and dentist (including their corporations, representatives, staff, agents, parents, guardians, children and all related individuals and entities) agree that all litigation events that occurred in the dental office will be determined through submission to an arbitrator, and NOT by a lawsuit or other legal proceeding filed in a federal, state, county or municipal court. By signing this Arbitration Agreement, the parties waive and forfeit their constitutional, statutory or common law rights for a jury or judge to decide any legal questions or disputes, and instead accept the sole use of a private arbitrator. This Arbitration Agreement covers all disputes as to dental treatment, financial matters or any other events that occurred in dental office whether in tort (intentional or negligent), contract, statute, common law or otherwise, and including without limitation all actions relating to dental negligence, return of fees, loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. The arbitration shall bind all parties, including without limitation any spouse or heirs, and will NOT be subject to court review. Either party may initiate arbitration by serving on the other a written "Demand for Arbitration" form by certified mail. No other form of service will be acceptable. The Demand for Arbitration must identify all parties, include their contact information, describe the claims against each party, and state the amount of damages sought. Either party then may continue the proceedings by contacting the American Arbitration Association ("AAA"). A single AAA arbitrator, mutually selected by the parties, will conduct the arbitration. All proceedings will be resolved using the AAA rules. Arizona law will apply. If any provision of this Arbitration Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and effect.

Patient Signature: _____ Witness Signature: _____

Patient Print Name: _____ Witness Print Name: _____

Date: _____

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? (*Check one:*) DAILY ☐ / WEEKLY ☐ / OCCASIONALLY ☐			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:	☐	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Oral Cancer Screening Consent Form

We are very concerned about oral cancer and conduct screening examinations on every patient. The incidence of Oral Cancer continues to rise in the USA. Approximately 45,750 people in the US will be newly diagnosed with oral cancer every year and one American dies every hour of every day.

Alarmingly, 25 % of the new oral cancer cases are people that do not have any of the traditional lifestyle risk factors, such as age and tobacco and alcohol use. Exposure to HPV (Human Papilloma Virus) is a newly discovered risk factor.

Traditionally, dentists and hygienists have done oral cancer screening with the naked eye, but VELscope (Visually Enhanced Lesion scope) will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.

VELscope, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope handpiece, and the dentist may find tissue abnormalities at an earlier stage. Before the exam, the room is darkened and much like "desert storm night vision technology" the clinician can see changes in tissue that may not be visible. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. However, the VELscope exam may or may not be covered by dental insurances. The fee is $40 if not covered. As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure.

Please sign the area below to accept the financial responsibility for this procedure.

Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients.

YES, I authorize the office to perform the VELscope examination.

Print Name _____

Signature _____

Date _____

NO, I understand the risks and choose not to have the VELscope examination.

Print Name _____

Signature _____

Date _____