NOTICE OF PRIVACY PRACTICES/ACKNOWLEDGEMENT OF RECEIPT

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. In addition to the copy we are providing you, copies of the current notice are available by accessing our website at www.brushdentalstudio.com and may be obtained through the office.

I acknowledge that I have received the Notice of Privacy Practices.

Signature of Patient or Patient's Representative	Date
Print Name	Relationship to Patient

Patient Care, Cancellation, and Financial Agreement

In consideration of my care, I agree to the following:

I accept full responsibility for the services provided for me by Brush Dental Studio. I understand that payment is due at the time of such services unless prohibited by an existing contract between Brush Dental Studio and an insurance company. For procedures that are billed to my insurance company, I understand that I become personally responsible for the charges, in the event my insurance company does not remit payment within 60 days. I have provided a credit card listed below to be charged for any outstanding account balances.

I understand that my insurance company may not cover all necessary balances and may send the check to the wrong party. In the event my insurance company sends a reimbursement check to me for services rendered but not yet paid to Brush Dental Studio, I hereby authorize the outstanding balance to be charged to the credit card I have provided below. If my insurance company remits payment to Brush Dental Studio for services that I have already paid or prepaid for, I understand that Brush Dental Studio will reimburse the form of payment I used to pay for my treatment. If my insurance company has made a partial payment for the treatment, I authorize Brush Dental Studio to collect any outstanding balance, co-pays, deductibles, and non—covered services payable by the credit card listed below.

I understand that Brush Dental Studio requires 2 business days notice for cancellations or the rescheduling of appointments. The failure to provide such notice will result in a $25 non-refundable deposit towards any future appointment. If I prefer to have dental appointment that are 2 hours or more, I agree to provide a non-refundable deposit of 50% of the service to be provided.

Brush Dental Studio has a 60 day policy, from the date of service that accounts be paid in full for each service rendered. Accounts that are over 60 days past due will be referred to our collection agency. The failure of patient/responsible party to make payments or to otherwise act in accordance with this Agreement shall be a default and should entitle Brush Dental Studio to withhold further services under this Agreement. If Brush Dental Studio resorts to legal proceedings to enforce this Agreement, Brush Dental Studio shall be entitled, in addition to such other relief as may be granted, to attorney's fees and costs incurred in connection with such proceeding.

Name_____

Credit Card Number_____(optional)

Expiration Date_____ Security Code (on back of card):_____

Signature_____Date_____

Insurance Disclaimer

I, _____, understand that my Co-Payment (patient financial responsibility) to Brush Dental Studio (BDS) is due at the time of service.

I understand that the amount of my co-payment, presented to me by BDS, is an **estimate only.**

I understand that the amount of my co-payment has been calculated utilizing two factors:

1. A **"Generic Fee Schedule"**(cost of dental service) provided to BDS by my Insurance Company at the beginning of each calendar year

2. My **"Dental Benefits Break Down"** (estimate of percentage to be paid by me and percentage to be paid by my Insurance Company for each dental service) provided to BDS by my Insurance company at the time of Insurance Verification prior to my treatment.

I understand that a Pre-Determination of benefits can be sent to my Insurance Company for each dental procedure recommended to me by BDS upon my request. In cases where I request such action, my treatment will be postponed until BDS receives my Insurances pre-determination, which can potentially take up to 6 weeks.

I understand that the amount of Co-Payment (patient financial responsibility) can change **(potentially increase)** after my insurance company has reviewed and processed my dental claim. In such cases, I will have an **outstanding balance with BDS that will be due within 60 days from the Date of Service.**

I understand that my Insurance company may deny the dental claim in its entirety. In such case, I am fully responsible for any outstanding balance on my account, within 60 days from the Date of Service.

I understand that regardless of whether my dental claim is paid, denied, under review, pending, processing, etc by my insurance company, I am responsible to pay BDS for any outstanding balance in 60 days from the Date of Service.

I understand that after 60 days, all matters of dispute with my insurance company must be handled directly by me.

_____ _____

Patient Signature Date

SMILE MAKEOVER ANALYSIS

When I see a picture of myself, the first thing I notice about my smile is:

Something I often notice about other smiles I consider attractive is:

Please mark an X by any statement that you agree with:

__ I wish the color of my teeth were whiter

__ I think some of my teeth are too small

__ I think some of my teeth are too long

__ I wish my teeth were straighter

__ I think my gums show too much when I smile

__ I think my smile shows too much space between some of my teeth

__ I am not totally pleased with my smile so I sometimes hesitate to smile

__ I have often wished I could change some of the features of my smile

__ I feel as though I don't really know all of the options available to enhance my smile

__ Concerns over fees have prevented me from taking advantage of some of the available options to enhance my smile

__ 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

TIME 12:51 PM | Brush Dental Studio | DATE 6/20/2013

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ 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? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ 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 _____

TIME 11:04 AM DATE 7/27/2013

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Credit Card : _____

Exp : _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00