Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may attain optimal oral health. Everyone benefits when office and financial policies are understood.

The following is our policy.

Payment is due at the time services are rendered. We accept cash, personal checks, money orders, Visa, MasterCard, Discover, American Express and Care Credit. Returned checks will be subject to additional fees. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. As a courtesy to you we will process all your insurance claims. We ask that you pay the deductible and co-payments, which is the estimated amount not covered by your insurance company at the time service is rendered to you. We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of insurance coverage. Insurance companies have a wide variety of rules, plan limitations, and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Unpaid balances over 30 days are subject to finance charges at a rate of 1.5% per month. Unpaid balances over 90 days are subject to being turned over to collections.

We extend a 10% courtesy discount for our seniors 65 years of age and older.

We extend a 5% discount on prosthetic services that are pre-paid in full. Acceptable form of payment is cash only. If you have insurance to be filed, we will file the claim on your behalf and the insurance company will reimburse you.

All patients must provide a form of ID and Insurance card (if applicable) to be copied at the time of the appointment.

We require personal contact telephone numbers as well as contact telephone number to use in case of an emergency.

Cancellation and Late Policy: Your appointment time is reserved for you. If you are late for your appointment we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated or if we will need to reschedule you. We maintain a very strict schedule and must insist that appointment times be respected. For cancellations we require 24 hour advanced notice or a cancellation charge will incur. An answer machine is available for messages left after business hours. Repeatedly missed appointments may result in dismissal as a patient.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies.

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## CONSENT

I have read, understand and agree to the above terms and conditions. I understand that responsibility for payment for dental services rendered in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance charge or collection charge will be added to any overdue balance.

Signature (patient or responsible party) _____ Date _____

Print Name (patient or responsible party) _____

## CONSENT TO THE USE AND DISCLOSURE OF THE HEALTH INFORMATION FOR THE TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby acknowledge receipt of a written notice of my privacy rights and I consent to DENTAL PROFESSIONAL ASSOCIATES, LLC using and disclosing my protected health information to carry out treatment, payment or healthcare operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more'. complete description of how my protected health information may be used or disclosed, I understand that I have the right to review the notice prior to signing this consent.

I understand that DENTAL PROFESSIONAL ASSOCIATES, LLC reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request addressed to MICHAEL LAMB, DDS c/o DENTAL PROFESSIONAL ASSOCIATES, LLC, 1160 VARNUM ST., NE #006, WASHINGTON, DC 20017.

I understand that I have the right to restrict how DENTAL PROFESSIONAL ASSOCIATES, LLC uses or disclose my protected health information to carry out treatment, payment or health care operations: that DENTAL PROFESSIONAL ASSOCIATES, LLC is not required to agree to the restrictions and; that DENTAL PROFESSIONAL ASSOCIATES, LLC is bound by restrictions to which it agrees.

I request the following restrictions to how my health information is used or disclosed:

I have the right to revoke this consent by notifying DENTAL PROFESSIONAL ASSOCIATES, LLC in writing, except to the extent that DENTAL PROFESSIONAL ASSOCIATES, LLC has taken action in reliance on my consent.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or patient's representative's authority to act for the patient

DPA
dentalprofessional
ASSOCIATES

PATIENT NUMBER

Age _____ Date _____

Patient's Name _____ Date of Birth _____ ☐ Male ☐ Female
Last First Initial

If Child? Parent's Name _____

How do you wish to be addressed? _____
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Residence - Street _____

City State Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: ☐ Insurance ☐ Cash ☐ Credit Card

Purpose of Call _____

Other Family Members in this Practice _____

Who may we thank for this referral _____

Patient/Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you

_____

_____

## DENTAL INSURANCE - 1ST COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

## DENTAL INSURANCE - 2ND COVERAGE

Employee Name _____ Date of Birth _____
Relationship to patient _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____

Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

## CONSENT:

I consent to th diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing. I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less that the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____

Date _____

# REGISTRATION

DPA
dentalprofessional
ASSOCIATES

PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW' ON THE LINE AFTER THE QUESTION

1. Physician's Name_____
   Address _____ Tel: _____
2. Are you under a physician's care?.....☐YES ☐NO
   Since when_____ Why_____
3. When was your last complete physical exam?_____
4. Are you taking any medication or substances?.....☐YES ☐NO
   (If yes, please list medications in comments section or on the back of this form)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products)☐YES ☐NO
6. Are you allergic to any medications or substances? (please list) .....☐YES ☐NO
7. Do you have any other allergies or hives?.....☐YES ☐NO
8. Do you have problems with penicillin, antibiotics, anesthetics or other meds?..☐YES ☐NO
9. Are you sensitive to any metals or latex?.....☐YES ☐NO
10. Are you pregnant or suspect you may be?.....☐YES ☐NO
11. Do you use any birth control medications?.....☐YES ☐NO
12. Have you ever been treated for or been told you might have heart disease?.....☐YES ☐NO
13. Do you have a pacemaker, an artificial heart valve implant, or have been diagnosed with mitral valve prolapse? .....☐YES ☐NO
14. Have you ever had rheumatic fever? .....☐YES ☐NO
15. Are you aware of any heart murmurs?.....☐YES ☐NO
16. Do you have high or low blood pressure? .....☐YES ☐NO
17. Have you ever had a serious illness or major surgery?.....☐YES ☐NO
    If so, explain _____
18. Have you ever had radiation treatment, chemo treatment for tumor growth or other condition?.....☐YES ☐NO
19. Have you hever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? ☐YES ☐NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism?.....☐YES ☐NO
21. Do you have any artificial joints/prosthesis? .....☐YES ☐NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? .....☐YES ☐NO
23. Have you ever bled excessively after being cut or injured? .....☐YES ☐NO
24. Do you have any stomach problems?.....☐YES ☐NO
25. Do you have any kidney problems? .....☐YES ☐NO
26. Do you have any liver problems? .....☐YES ☐NO
27. Are you diabetic? .....☐YES ☐NO
28. Do you have fainting or dizzy spells?.....☐YES ☐NO
29. Do you have asthma? .....☐YES ☐NO
30. Do you have epilepsy or seizure disorders?.....☐YES ☐NO
31. Do you or have you had venereal or any sexually transmitted disease? .....☐YES ☐NO
32. Have you tested HIV positive?.....☐YES ☐NO
33. Do you have AIDS? .....☐YES ☐NO
34. Have you had or do you test positive fowr hepatitis? .....☐YES ☐NO
35. Do you or have you had T.B.? .....☐YES ☐NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? .....☐YES ☐NO
37. Do you regularly consume more than one or two alcoholic beverages a day? ...☐YES ☐NO
38. Do you habitually use controlled substances? .....☐YES ☐NO
39. Have you had psychiatric treatment? .....☐YES ☐NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? .....☐YES ☐NO
41. Do you have any disease condition, or problem not listed? If so, explain_____
    _____
42. Is there anything else we should know about your health that we have not covered in this form?_____
43. Would you like to speak to the Doctor privately about any problem? .....☐YES ☐NO

COMMENTS

ANEST.

MED. ALERT

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE_____ DATE _____
DENTIST'S SIGNATURE_____ DATE _____

# MEDICAL HISTORY

DPA
dentalprofessional
ASSOCIATES

PATIENT NUMBER

Patient's Name _____
Last First Initial Date of Birth

1. Purpose of initial visit_____
_____
2. Are you aware of a problem?_____
_____
3. How long since your last dental visit?_____
4. What was done at that time?_____
_____
5. Previous dentist's name_____
Address:_____ Tel. _____
6. When was the last time your teeth were cleaned?_____

MARK THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ☐YES ☐NO
How often:_____
8. Were dental x-rays taken? ☐YES ☐NO
9. Have you lost any teeth or have any teeth been removed? ☐YES ☐NO
Why?_____
10. Have they been replaced? ☐YES ☐NO
11. How have they been replaced?
a. Fixed bridge _____ Age _____
b. Removable bridge _____ Age _____
c. Denture _____ Age _____
d. Implant _____ Age _____
12. Are you unhappy with the replacement? ☐YES ☐NO
If yes, explain:_____
13. Would you like to know about permanent replacements? ☐YES ☐NO
14. Have you ever had any problems or complications with a previous dental treatment? ☐YES ☐NO
If yes, explain: _____
15. Do you clench or grind your teeth? ☐YES ☐NO
16. Does your jaw click or pop? ☐YES ☐NO
17. Have you experienced any pain or soreness in the muscles of your face or around your ear? ☐YES ☐NO
18. Do you have frequent headaches, neck aches or shoulder aches? ☐YES ☐NO
19. Does food get caught in your teeth? ☐YES ☐NO
20. Are any of your teeth sensitive to: ☐Hot? ☐Cold? ☐Sweets? ☐Pressure?
21. Do your gums bleed or hurt? ☐YES ☐NO
When? _____
22. Do you experience dry mouth? ☐YES ☐NO
23. How often do you brush your teeth? _____ When? _____
24. Do you use dental floss? ☐YES ☐NO
How often? _____
25. Are any of your teeth loose, tipped, shifted or chipped? ☐YES ☐NO
26. Are you unhappy with the appearance of your teeth? ☐YES ☐NO
27. How do you feel about your teeth in general? _____
28. Do you feel your breath is offensive at times? ☐YES ☐NO
29. Have you ever had gum treatment or surgery? ☐YES ☐NO
What?_____
Where?_____
When? _____
30. Have you had any orthodontic work?_____
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?_____
32. Do you have any questions or concerns? ☐YES ☐NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

COMMENTS

ANEST.

MED. ALERT

PATIENT'S/GUARDIAN'S SIGNATURE_____ DATE _____
DENTIST'S SIGNATURE_____ DATE _____

# DENTAL HISTORY