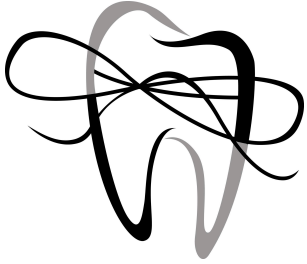


Hazel Dell Dentistry

Consent of Treatment

The undersigned hereby authorizes Drs Suzette Nikas and Jillian Joyce and or designated staff members to take necessary radiographs, study models, photographs, or any other diagnostic aids required to make a thorough diagnosis of existing conditions. I further authorize Drs Suzette Nikas and Jillian Joyce, or designated staff members to perform any and all forms of treatment, including administering of medications and delivery of therapy that may be indicated. I understand that the use of any anesthetic agents involve certain risks that will be discussed prior to treatment.

Missed, Failed and Cancelled Appointments

There is a $50 charge for all missed, failed, and cancelled appointments without a 24- hour notice.

Returned Check:

Returned checks will be subject to a $50 returned check fee and will result in possible cash only transactions with future visits.

Financial Agreement

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, and Care Credit

I hereby agree to be responsible for charges for all services rendered by Hazel Dell Dentistry. I hereby assign directly to Hazel Dell Dentistry payment of my dental insurance benefits applicable to these services and authorize the collection of such funds on my behalf. Such payments shall not exceed my balance owed to Hazel Dell Dentistry. I acknowledge and understand that I am the guarantor whether signing or my behalf, or if signing as a patient's agent, legal guardian, or closest relative. I am personally responsible for all charges not paid by my insurance. It is my responsibility to be aware of the insurance benefit available for each dental treatment. Delayed or denied insurance payments could result from missing or incorrect information. I also certify that any information which I have provided is true and correct.

In the event of non-payment, I will be held liable for collection costs including but not limited to: collection agency fees, reasonable attorney fees which you expressly agree shall be the greater of: (1) fifty percent (50%) of the unpaid balance or (2) $400 court costs and interest at a rate of 18% per year, calculated daily, beginning from the last date of service or the last payment date. Unpaid balances shall also be subject to a data transfer of derogatory information about any unpaid balance to one or all of the three major credit bureau reporting agencies (Experian, Equifax or Trans Union) By signing below, you expressly authorize any collection agency or attorney involved to not only transmit this information, but also to request a copy of your personal credit report from one or more of the above referenced credit reporting agencies.

I certify that I have read and understand the above financial agreement as well as the medical and dental history form. To the best of my knowledge, the written questions have been accurately answered.

Signature of Patient/Guardian/Parent of Minor

X_____ **Date:** _____

Printed:_____

Patient Registration Information

Hazel Dell Dentistry

Date _____

Name _____
Last First M Preferred

Address _____ City _____ State ___ Zip _____

E-Mail _____ Birthdate _____

Home Phone _____ Work Phone _____ Cell Phone _____

How would you like for us to contact you? ❑ Phone ❑ Text ❑ Email

Drivers License #_____ Social Security # _____

Are You: ❑ Minor ❑ Single ❑ Married ❑ Other _____
❑ Male ❑ Female

Employer (Parent's employer if minor) _____Work Phone _____

Occupation _____Spouse's name (Parent's name if minor) _____

Spouse's Birthdate _____ Work Phone _____

Emergency contact other than spouse or parent _____Phone _____

Whom may we thank for referring you? _____

What did you like or dislike about your previous dental office? _____

Responsible Party

☐ Check if same as above

Person responsible for this account _____Relationship_____

Address _____ Home Phone _____

City, State, Zip _____

Insurance Information

Name of policyholder_____

Relationship to patient _____

Birthdate _____Insurance ID #_____SSN:_____

Address if different from above _____

Insurance Company _____ Phone #_____

Do you have additional insurance? ❑ Yes ❑ No If yes, complete the following:

Name of policyholder_____

Relationship to patient _____

Birthdate _____ Insurance ID # _____ SSN: _____

Address if different from above _____

Insurance Company _____ Phone # _____

Patient Name: _____

MEDICAL & DENTAL HISTORY

Medical Physician Name: _____ Office Phone No. _____

Previous Dentist Name: _____

How long has it been since your last cleaning & exam? ❑ 6-12 months ❑ 1-2years ❑ 2 years or more

1. Are you allergic to any of the following? **If yes, check box; otherwise leave blank.**

❑ Penicillin/Amoxicillin ❑ Local Anesthetic:_____ ❑ Metal: (Nickel, etc.) _____ __
❑ Keflex ❑ Epinephrine ❑ Other:
❑ Sulfa ❑ Latex _____

If yes to any of the following, check box; otherwise leave blank.

2. ❑ Are you taking any medications?
   If yes, list medications: _____
   _____
   _____
   _____
3. ❑ Do you require any pre-medication prior to dental treatment?
4. ❑ Have you ever been hospitalized for any surgical operation or serious illness within the past 5 years?
   If yes, identify: _____
5. ❑ Do you smoke?
6. ❑ Do you chew tobacco?
7. ❑ Do you drink alcohol?
8. ❑ Do you use any other drugs?
9. ❑ Have you had a panoramic (full mouth) x-ray taken within the last 3 years?
10. ❑ Have you had cavity detection (bitewing) x-rays taken within the last year?
11. ❑ Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

WOMEN ONLY

12. ❑ Are you Pregnant?
13. ❑ Are you taking birth control medication?

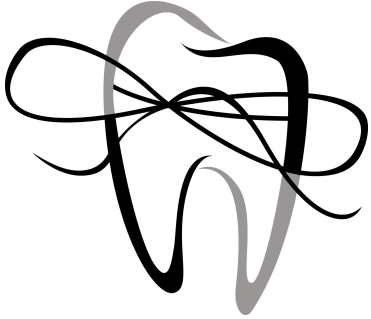
13. Have you had or do you currently have any of the following conditions?
If yes, check past or current box; otherwise leave blank.

Past	Current		Past	Current		Past	Current	
❑	❑	Rheumatic Fever	❑	❑	Diabetes: ❑ Type 1 ❑ Type 2 Controlled by: ❑ Diet ❑ Medication ❑ Insulin	❑	❑	Low Blood Pressure
❑	❑	Heart Murmur				❑	❑	High Blood Pressure
❑	❑	Heart Attack				❑	❑	Seizures
❑	❑	Heart Disease				❑	❑	Epilepsy
❑	❑	Angina	❑	❑	Cancer Type: _____ Treatment: ❑ Radiation ❑ Chemo ❑ Surgery	❑	❑	Stroke
❑	❑	Cardiac Pacemaker				❑	❑	Arthritis
❑	❑	Heart Valve Replacement				❑	❑	Hepatitis: A, B, or C (circle one)
❑	❑	Thyroid Disease						
❑	❑	Kidney Disease	❑	❑	Asthma	❑	❑	AIDS or HIV Infection
❑	❑	Liver Disease	❑	❑	Respiratory Problems	❑	❑	Joint Replacement
❑	❑	Anemia	❑	❑	Hay Fever/Allergies	If yes, which joint? _____		
❑	❑	Other: _____						

If yes to any of the following, check box; otherwise leave blank.

14. ❑ Do your gums bleed while brushing or flossing?
15. ❑ Are your teeth sensitive to hot or cold liquids/foods?
16. ❑ Are your teeth sensitive to sweet or sour liquids/foods?
17. ❑ Do you feel pain in any of your teeth?
18. ❑ Do you have any sores or lumps in or near your mouth?
19. ❑ Have you ever had any head, neck or jaw injuries?
20. ❑ Have you ever experienced any of the following problems in your jaw?
    - ❑ A) Clicking
    - ❑ B) Pain (Joint, Ear, Side of Face)
    - ❑ C) Difficulty in opening or closing?
    - ❑ D) Difficulty in chewing?
21. ❑ Do you have frequent headaches?
22. ❑ Do you clench or grind your teeth?
23. ❑ Do you bite your lips or cheeks frequently?
24. ❑ Have you ever had any difficult extractions in the past?
25. ❑ Have you had any orthodontic treatment?
26. ❑ Have you ever had prolonged bleeding following extractions?
27. ❑ Have you ever had instruction on the correct method of brushing your teeth and care of your gums?
28. ❑ Do you have any dental cosmetic concerns?
    ❑ Color of Teeth ❑ Teeth Alignment
29. ❑ Have you bleached/whitened your teeth before?
30. ❑ Are you interested in: ❑ Bleaching/Whitening ❑ Veneers ❑ Straighter Teeth

If none of the above boxes have been checked, please initial____



Hazel Dell Dentistry

HIPAA AUTHORIZATION FORM

Patient's Full Name | **Patient's Date of Birth**

Address | **Patient's Telephone Number**

City, State Zip Code

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose personal information about me:
   Hazel Dell Dentistry
2. The following person (or class of persons) may receive disclosure of protected health information about me: **OR** None ☐

   check if address is the same as the patient's ☐

   Name

   Address

   City, State Zip Code

   check if address is the same as the patient's ☐

   Name

   Address

   City, State Zip Code

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying Hazel Dell Dentistry in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature of Individual
(The person about whom the information relates)

Date of Individual's Signature

OR, if applicable –

Signature of Guardian or Personal Representative of Patient's Estate

Date of Guardian's/Personal Representative's Signature

Description of Authority to Act for the Individual