WELCOME

EMAIL ADDRESS:_____

PATIENT INFORMATION

Patient Name:_____

Occupation:_____ Marital Status:_____

Employer address:_____

Spouse Name:_____ Birthdate:_____ SS#_____

Whom may we thank for referring you?_____

DENTAL INSURANCE AND/OR ACCOUNT RESPONSIBILITY

Who is responsible for this account?_____

Relationship to patient:_____ Ins Co._____ Group #_____

Ins. Co address_____

Is patient covered by an additional insurance? Y / N

Subscriber's Name:_____ Birthdate_____ SS#_____

Relationship to Patient:_____ Ins Co._____Group #_____

Ins Co. Address:_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ And assign directly to treating doctor all insurance benefits. If any, otherwise payable to me for services rendered. I understand that i am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____

Relationship:_____ **Date:**_____

PHONE NUMBERS

Cell:_____ Home:_____ Work:_____
Best time to reach you _____

Do you prefer to be contacted by: (circle one) Email Text Phone

EMERGENCY CONTACT: Name:_____ Relationship:_____
Phone number: C / H / W_____

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ❑ F ❑	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

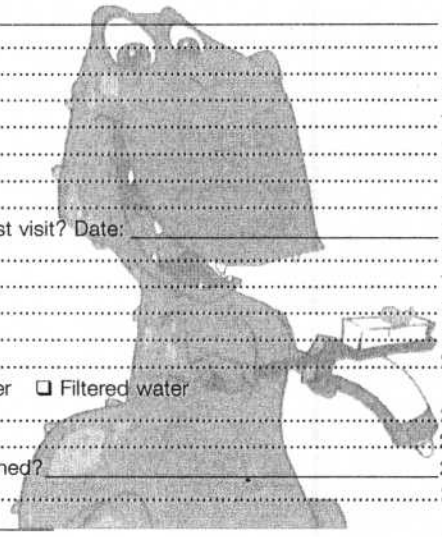
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician_____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



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. 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.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

GENERAL CONSENT FOR TREATMENT

I _____, understand that this treatment plan is based on the current knowledge of my clinical conditions. I understand that during the course of treatment clinical conditions may change necessitating a change in the treatment plan and that I will be fully informed of any changes. I have been provided an opportunity to ask any questions regarding my treatment including the risks and benefits of care or not receiving care and I have had them addressed satisfactorily. I understand that some of my dental needs cannot be treated at this office and that those items have been identified. I further understand that this treatment plan and estimate has been created without considering insurance limits and deductibles, as these amounts may change prior to the completion of treatment. The patient's estimated amounts have not been verified with my insurance carrier. The total cost of treatment is my responsibility. Estimated patient amounts, co-pays, and deductibles must be paid on the date of service, unless alternate arrangements have been made prior to treatment. An insurance claim will then be submitted to my insurance carrier. When payments are received from the insurance carrier any amounts not covered will be billed to me and I will receive a statement. I have read, understand and now give my permission for treatment at Dedicated Dentistry for myself or the minor patient named above.

_____

Patient Signature

_____

Date

_____

Provider

OFFICE POLICIES

Welcome to the office of Tavi Henry D.D.S, P.C. We feel it is important to inform you of our policies prior to you seeing the Doctor.

We will bill all insurance claims as a courtesy to our patients. Any claims not paid by insurance within 90 days will be turned over to patient for reimbursement. The ultimate responsibility for payment of charges is the patient's, regardless of the type of insurance a patient has. Insurance reimbursement is a contract between the patient and the insurance carrier.

We request you pay your copay and non-covered charges at the time of service unless previous arrangements have been made. We accept cash, checks, Visa, MasterCard, American Express and Discover. Any balances not paid by insurance will be assessed an interest charge after 60 days. Any delinquent accounts older than 90 days will be turned over to collection.

Once a patient is sent to collections, they will be asked to choose another Dentist.

We will attempt to give our patients a reminder call the business day prior to their appointment. We request that if you have to change your appointment you do so 24 hours in advance as a courtesy to us and other patients who want to be seen. Leaving a message on the answering service does not constitute notice when we do not have time to fill the appointment. ***Patients who do not cancel or reschedule at least 24 hours in advance will be charged $45/hour scheduled, there will also be a $45 charge for patient who no-show for an appointment.*** Patient who no-show or cancel 3 times will be asked to seek care elsewhere.

Patient's requesting a copy of their records must do so in writing. There will be a nominal charge to copy the records, based on the size of the patient's file.

Patients will be seen for the type of treatment and diagnostic appointment scheduled only. If additional treatment and/or diagnostics are required, the patient may be requested to return for another visit.

We ask that all paperwork required be filled out prior to seeing the Doctor. The patient must have a current ID card complete with claim mailing address. Please verify that Dr. Henry is listed as a provider of that you are able to go out of network. If Dr. Henry is not listed as a provider, the patient is responsible for payment at the time of service.

IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THEIR INSURANCE BENEFITS

_____ _____

Signature Date

TRUTH IN LENDING
EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES

INTEREST RATES AND INTEREST CHARGES	
Annual Percentage Rate (APR) for Purchases	**15.00%**
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.
Minimum Interest Charge	**If you are charged interest, the charge will be no less than $1.00**

FEES	
Late Charge	**$1.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $5.00**
Non-Sufficient Funds (NSF) Fee	**$25.00 per payment**

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

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\- I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity

Dental Entity Name: Dedicated Dentistry

Patient Signature:____ Date:________________________