

PATIENT REGISTRATION AND MEDICAL HISTORY

Date _____ (Please Print Legibly) Home/Cell Phone _____

Patient _____
 Last name First name Initial Preferred name

Street Address _____ City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Spouse/Parent Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse/Parent's Social Security _____

Name of Dental Insurance Company _____ Group Number _____

In case of Emergency, who should we notify? _____ Phone _____

Whom may we thank for referring you? _____

DRIVER'S LICENSE # _____

EMAIL ADDRESS: _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Are you under a physician's care now? Yes No
 Have you ever been hospitalized or had a major operation? Yes No
 Have you ever had a serious head or neck injury? Yes No

Are you taking any medications, pills, or drugs? Yes No
 Do you use tobacco? Yes No
 Do you use controlled substances? Yes No

If you answered yes to any of the above, please explain: _____

Do you have, or have you had, any of the following? (check if yes)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Stomach/Intestinal |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Epilepsy or Seizure | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Liver Disease/Jaundice | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Radiation Treatment | |

Have you ever had any serious illness not listed above? Yes/No If yes, please explain: _____

(Women) Do you suspect that you are pregnant? Yes/No Are you nursing? Yes/No

Are you allergic to any of the following? Aspirin Penicillin Codeine Metal Latex Local Anesthetics Other: _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will NOT hold my dentist or any member of his/her staff responsible for any error or omissions that I may have made in the completion of this form.

Date _____ Signature _____

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

_____ Date _____ Signature

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Stirling Dental Inc.
9720 Stirling Road #211
Suite 211
(954) 431-1869 (Dr. Sheriff)
(954) 437-6855 (Dr. Ziadie)

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our information form before seeing the Doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA OR MASTERCARD.

Regarding Insurance:

We may accept assignment of insurance benefits. However, we do require 20-30% of the bill to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do not accept assignment of benefits, we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance.

If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your credit card or the extended payment plan; it is now your responsibility. Please be aware that some, and perhaps all of these services may be non-covered services and not considered reasonable by your insurance policy.

Regarding Insurance Plans where we are a participating provider:

All co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates

Our Practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at the time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, or payment by cash or check at the time before services are rendered.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy and agree to the policy set forth.

X _____
Signature of Patient or Responsible Party

Date _____

X _____
Signature of Co-Responsible Party

Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: SHARON KIELER

Telephone: (954) 437-6855 Fax: (954) 431-5740

E-mail: ezdental1@comcast.net

Address: 9720 Stirling Road #211 Cooper City, FL 33024

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

STIRLING DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/13/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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 your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.15 for each page, \$2.50 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: SHARON KIELER

Telephone: (954) 437-6855

Fax: (954) 431-5740

E-mail: ezdena11@comcast.net

Address: 9720 Stirling Road #211 Cooper City, FL 33024

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, 25% of oral cancer victims have no lifestyle risk factors.

Oral Cancer Risk profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with any of the following:
 - Tobacco use
 - Chronic alcohol consumption
 - Oral HPV infection

Highest risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer
- 25% of oral cancers occur in people who don't smoke and have no other risk factors.

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is \$_____.

Yes, I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No, I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____



