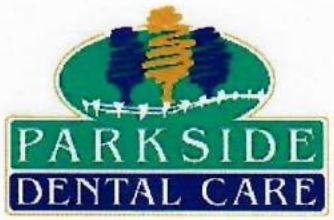


Patient Name _____ Birth Date_____ SS#_____

Address _____Preferred Name:_____

City_____ State_____ Zip_____

Employer_____ Occupation _____

Home phone_____ Work _____ Cell_____

Email address_____

Marital Status _____Single ___Married ___Separated ___Divorced ____Child ____Other

Emergency Contact Name_____ Relationship to patient _____

Home _____ Work_____

How did you hear about us? _____

IF PATIENT IS UNDER 18 YEARS OLD

Person responsible for account of minor child _____ Relationship to patient_____

Address (If different from above)_____

Home phone_____ Work _____ Cell_____

Place of Employment_____ Birth Date_____ SS#_____

Do you have dental insurance? ____Yes _____No

Dental Insurance Company Name _____

Subscriber Name_____ Birth Date_____ Relationship to Patient_____

ID#_____ Group Name _____ Group #_____ Phone# _____

Do you have secondary dental insurance? ____Yes _____No

Dental Insurance Company Name _____

Subscriber Name_____ Birth Date_____ Relationship to Patient_____

ID#_____ Group Name _____ Group #_____ Phone# _____

PCP Name (Medical Doctor) _____ PCP Phone # _____

What is the reason for your visit?_____

Former Dentist_____ City/State _____

Date of last dental visit _____Date of last dental x-rays_____

How often do you brush? _____ How often do you floss? _____

Dental History- Mark all that apply:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blister on lips/mouth
- ☐ Burning sensation
- ☐ Chewing on one side of mouth
- ☐ Tobacco use
- ☐ Clicking/popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collecting between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen/tender
- ☐ Jaw pain/ tiredness
- ☐ Lip/cheek biting
- ☐ Loose teeth/ broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain when brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores /growths in mouth

Please list any medications that you are currently taking:

_____ _____

_____ _____

Pharmacy Name_____ Phone Number _____

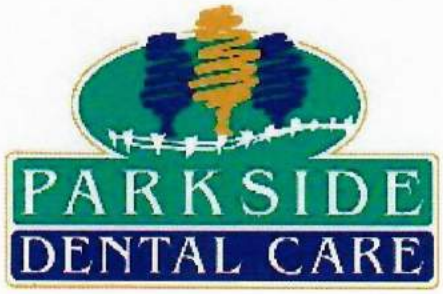
Allergies- Mark all that apply:

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthesia
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

Medical History- Mark all that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints
  - Joint type: _____
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding/ Blood Disorder
- ☐ Blood Thinners
- ☐ Biphosphate Compounds (Actonel, Fosomax, etc.)
- ☐ Chemotherapy
- ☐ Circulation Problems
- ☐ Congenital Heart Lesions
- ☐ Contact Lenses
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis- Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Pregnant/Breastfeeding
- ☐ Premed for Dental Procedures
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seasonal Allergies
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Taking birth control
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor/Growth on head/neck
- ☐ Ulcer
- ☐ Venereal Disease

Signature _____ Print Name_____ Date_____



6713 Taylor Circle • Montgomery, AL 36117 • 334-271-9916 • parksidedentalcare.com

Important for Our Patients

Dental Insurance & Payment Policy:
We are glad to help you in obtaining the maximum reimbursement from your dental insurance plan. Most plans only assist with a portion of the dental fee, which means you will be responsible for your total treatment fee at the time of service. Once your plan has been verified, we will file the claim on your behalf as a courtesy to you. Payment is expected at the time of service, unless prior arrangements have been made. For your convenience we accept: Cash, Personal Check, VISA, MasterCard, Discover, American Express, Debit cards and CareCredit. In the case of a returned check, there will be a $30 charge added to the total amount due.

I agree to be financially responsible for the cost of all services rendered to the patient by this office, and, I understand that if payment is not made when due, I agree to pay interest on the balance at 1.5 % monthly (18 % annually). In the event legal action results I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.3%), attorney fees, and/or court costs if such be necessary.

Signature:_____ **Date:**_____

Appointments:
We respect the importance of your time and work very hard to schedule appointments that accommodate the busy needs of all our patients. We reserve specific times for your care and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your scheduled time. However, a verbal confirmation is required 24 hours prior to your appointment time. There is a $20 charge for any appointments that are cancelled or reschedule without proper notice.

Assignment and Release:
We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance for reimbursement.

I understand all information held herein and guarantee that all the information given is correct to the best of my knowledge. I also accept the responsibility in immediately providing any changes in information, provided by me to this office.

I hereby authorize payment go directly to Ronald T. Barganier, DMD for dental benefits otherwise payable to me. If my insurance policy dictates that payment be made directly to me, the patient, then I authorize that payment be addressed to and endorsed by Ronald, T. Barganier, DMD.

Signature:_____ **Date:**_____

Express Prior Consent to contact consumer by cell phone:
I agree, in order for us to service your account or to collect monies due, Parkside Dental Care and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Parkside Dental Care, its employees and/or agents may contact me as described above.

Signature:_____ **Date:**_____

Privacy Rule:
Because there can be questions of privacy when health care information is transmitted electronically, the Congress has established an all-inclusive sweeping privacy law called the Health Insurance Portability and Accountability Act (HIPAA) to be administered by the Department of Health and Human Services. The Act established standards for health care providers in obtaining and disclosing your personal health information.

Although such information exchange has been routine in the past, and even though we have never had a problem, the law mandates that you must now give specific written consent to continue these traditional communications relating to your personal health information in order to plan and accomplish optimum treatment, to convey and receive pertinent health information, and to facilitate payment.

We fully respect the privacy of your medical records, and we will continue to do all we can to make them secure and to protect their confidentiality. In order to provide the best possible health care and/or to help third parties involved with payment of your account we routinely share and request pertinent health information only with your other medical or dental caregivers, with other concerned parties such as relatives, and with others involved in account payment such as insurers, etc. We may from time to time need to confirm or discuss appointments or to discuss care related concerns on your home answering machine or directly to those answering your home phone or to phone callers identifying themselves as a relative or concerned party

In the course of your treatment we sometimes have to disclose or receive your personal health information from other treatment related facilities (such as laboratories, sleep clinics, pathologists, and radiologists) that might not be required to obtain your consent to release to us products or reports relating to your personal health.

HIPAA allows you to consent or refuse to the use or disclosure of your personal health information as described above, but consent or refusal must be in writing. HIPAA does recognize the necessity of information exchange for optimum patient care, and it has provided for denial of treatment if you choose not to consent. If you choose to give consent by signing this document, you have the future right to revoke or restrict part or all of this Personal Health Care Information Agreement, but you may not revoke or restrict actions that have already been taken that relied on this or a previously signed consent. Of course you personally have the right at any time to access any information we have in your personal health records. Your signature below to indicates that you consent.

Please list anyone with whom we may release your records or information to: _____

_____

_____

Please ask for our Privacy Coordinator if you have any questions concerning this form or if you desire to review a full copy of our Notice of Privacy Practices.

Signature:_____ **Date:**_____