DENTAL HISTORY

Name________________________________ Nickname_______________________________ Age__________
Referred by____________________________How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist ________________________________How long have you been a patient?____________Months/Years
Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

PERSONAL HISTORY

	Question	YES	NO
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]____________________	☐	☐
2.	Have you had an unfavorable dental experience?____________________	☐	☐
3.	Have you ever had complications from past dental treatment?____________________	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?____________________	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?____________________	☐	☐
6.	Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?______________	☐	☐

GUM AND BONE

	Question	YES	NO
7.	Do your gums bleed or are they painful when brushing or flossing? ____________________	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? ____________________	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth? ____________________	☐	☐
10.	Is there anyone with a history of periodontal disease in your family? ____________________	☐	☐
11.	Have you ever experienced gum recession? ____________________	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ____________	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth? ____________________	☐	☐

TOOTH STRUCTURE

	Question	YES	NO
14.	Have you had any cavities within the past 3 years?____________________	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ____________________	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ____________________	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?____________________	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line? ____________________	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?____________________	☐	☐
20.	Do you frequently get food caught between any teeth?____________________	☐	☐

BITE AND JAW JOINT

	Question	YES	NO
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ____________________	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your back teeth together?____________________	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ______________	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?______________	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped? ____________________	☐	☐
26.	Are your teeth developing spaces or becoming more loose? ____________________	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?__	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?____________________	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ____________________	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore?____________________	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?___	☐	☐
32.	Do you wear or have you ever worn a bite appliance? ____________________	☐	☐

SMILE CHARACTERISTICS

	Question	YES	NO
33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?____________________	☐	☐
34.	Have you ever whitened (bleached) your teeth? ____________________	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth? ____________________	☐	☐
36.	Have you been disappointed with the appearance of previous dental work? ____________________	☐	☐

Patient's Signature ____ Date ____________________
Doctor's Signature ____ Date ____________________

© 2016 Kois Center, LLC
To order, please visit: **www.koiscenter.com**

MEDICAL HISTORY

Patient Name ______________________________ Nickname ____________________ Age ________

Name of Physician/and their specialty ______________________________

Most recent physical examination ______________________________ Purpose ______________________________

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury ____________________
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - chlorhexidine (CHX)
   - metals (nickel, gold, silver, ___________)
   - latex
   - nuts ____________________
   - fruit ____________________
   - other ____________________
3. heart problems, or cardiac stent within the last six months ___
4. history of infective endocarditis ____________________
5. artificial heart valve, repaired heart defect (PFO) __________
6. pacemaker or implantable defibrillator ____________________
7. orthopedic implant (joint replacement) ____________________
8. rheumatic or scarlet fever ____________________
9. high or low blood pressure ____________________
10. a stroke (taking blood thinners) ____________________
11. anemia or other blood disorder ____________________
12. prolonged bleeding due to a slight cut (INR > 3.5) __________
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___
14. chronic ear infections, tuberculosis, measles, chicken pox ___
15. asthma ____________________
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease ____________________
18. liver disease ____________________
19. jaundice ____________________
20. thyroid, parathyroid disease, or calcium deficiency _________
21. hormone deficiency ____________________
22. high cholesterol or taking statin drugs ____________________
23. diabetes (HbA1c = _______) ____________________
24. stomach or duodenal ulcer ____________________
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ____________________

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___
27. arthritis ____________________
28. autoimmune disease ____________________ (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma ____________________
30. contact lenses ____________________
31. head or neck injuries ____________________
32. epilepsy, convulsions (seizures) ____________________
33. neurologic disorders (ADD/ADHD, prion disease) ________
34. viral infections and cold sores ____________________
35. any lumps or swelling in the mouth ____________________
36. hives, skin rash, hay fever ____________________
37. STI/STD/HPV ____________________
38. hepatitis (type ____) ____________________
39. HIV/AIDS ____________________
40. tumor, abnormal growth ____________________
41. radiation therapy ____________________
42. chemotherapy, immunosuppressive medication ________
43. emotional difficulties ____________________
44. psychiatric treatment ____________________
45. antidepressant medication ____________________
46. alcohol/recreational drug use ____________________

ARE YOU:

47. presently being treated for any other illness ___________
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ___________
49. taking medication for weight management ___________
50. taking dietary supplements ____________________
51. often exhausted or fatigued ____________________
52. experiencing frequent headaches ____________________
53. a smoker, smoked previously or use smokeless tobacco ___
54. considered a touchy/sensitive person ____________________
55. often unhappy or depressed ____________________
56. taking birth control pills ____________________
57. currently pregnant ____________________
58. diagnosed with a prostate disorder ________________

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ______________

Doctor's Signature ______________________________ Date ______________

ASA ______ (1-6)

© 2017 Kois Center, LLC

To order, please visit: **www.koiscenter.com**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date of this Notice: 02/06/2026

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

Special Protections for Substance Use Disorder (SUD) Records

For patients receiving treatment for substance use disorders, federal law (42 CFR Part 2) provides additional privacy protections beyond standard health information.

- **Heightened Confidentiality:** We will not disclose records identifying you as having a substance use disorder in civil, criminal, administrative, or legislative proceedings without your specific written consent or a specialized court order.
- **Single Consent for TPO:** You may choose to provide a single, written "Global Consent" that allows us to use and disclose your SUD records for all future treatment, payment, and health care operations.

- **Right to Revoke:** You have the right to revoke this consent at any time in writing, except to the extent that we have already taken action based on your prior permission.
- **Accounting of Disclosures:** You have the right to request a list of certain disclosures of your SUD records made for treatment, payment, and health care operations for the three years prior to your request.
- **Prohibition on Redisclosure:** Anyone receiving your SUD records is generally prohibited from sharing that information further unless you provide express written consent or the law specifically permits it.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health-related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the President or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to workers' compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

NOTIFICATION OF DATA BREACHES

We are required by law to maintain the privacy and security of your protected health information. In the event of a breach—which is the unauthorized acquisition, access, use, or disclosure of your unsecured health information—we will notify you promptly. This notice will be provided in writing via first-class mail (or via email if you have previously agreed to electronic communications) and will include a description of what happened, the types of information involved, and the steps we are taking to investigate the breach, mitigate losses, and protect against further occurrences.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a postcard, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

TELEHEALTH / VIRTUAL VISITS AND ELECTRONIC COMMUNICATIONS

From time to time, we may offer telehealth (virtual) visits or communicate with you electronically (for example, through a patient portal, secure video, email, or text) to provide care, answer questions, coordinate treatment, send reminders, or discuss billing matters. When we provide telehealth services, we may use technology vendors to help us deliver these services. These vendors may receive limited protected health information as needed to provide the service and are required to protect your information and may be required to sign a business associate agreement with us, as applicable. You may request that we communicate with you in a confidential way (for example, using a specific phone number, mailing address, email address, or through the patient portal). See the “Confidential Communications” right described in the Notice. Please tell us if you want to opt out of electronic communications or prefer a different method. Electronic communications can carry some risk of interception or misdelivery. We use reasonable safeguards to protect your information, and we encourage you to use secure methods (such as the patient portal) when available. If you choose to communicate with us by unencrypted email or text, you are acknowledging and accepting those risks. If you have questions about telehealth or electronic communications, contact the office contact person listed at the beginning of the Notice.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and

ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

Uses and Disclosures Requiring Your Authorization

Most uses and disclosures of your health information for marketing purposes, and disclosures that constitute a sale of your health information, require your written authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization. You may revoke such an authorization at any time in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or 60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the

amendment, to the office contact person at the address, fax or email shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment, or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Restrict Disclosures for Out-of-Pocket Payments: If you pay for a dental service or health care item out-of-pocket in full, you have the right to ask us not to share that information with your dental insurance or health plan for the purposes of payment or our operations. We are legally required to agree to this request unless a law requires us to share that information.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

I. Confidential Information Questionnaire

Patient's Legal Name: First Last _ Middle

Nickname

Date of Birth:

Sex: ☐ Male ☐ Female

Cell Phone:

Email Address

Home Phone Number

Work Phone Number

Patient's Address

United States ▼ Address line 1 Address line 2 City

State/Province ▼ Zip/Postal Code

Marital Status

☐ Single ☐ Married / Common-law partner ☐ Widowed ☐ Divorced / Separated ☐ Under 18

☐ Prefer not to answer

Who can we thank for referring you to our office?

Employer (Patient's / Guardian's) Full Name

Occupation

II. Emergency Contact Information

Person we may contact in case of an emergency (other than your family home)

Name

Relationship

Cell Phone Number

Home Phone Number

Work Phone Number

III. Request For Confidential Communication

As my dental care provider, you may do the following with my permission:

- [ ] Check all
- [ ] Leave message on my voicemail / answering machine
- [ ] Contact me via email
- [ ] Contact me on the phone numbers provided

- [ ] I agree that the dental practice may communicate with me electronically at the email address and cell phone number i provided. I am aware that there is some level of risk that third parties might be able to read unencrypted emails or text messages.I am responsible for providing the dental practice any updates to my email address and cell phone number.
I can withdraw my consent to electronic communications by contacting the dental office

IV. Confirmation

Do you prefer a reminder before you appointment ☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

V. Dental Insurance And Financial Information

Dental Insurance Coverage ☐ Yes ☐ No

Dental insurance Company Name --

Dental insurance Address --

Dental insurance Phone Number (201) 555-0123

Subscriber's Name Full Name

Subscriber's ID Subscriber ID

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

Subscriber's Birthday

Subscriber's Address

Country ▼ Address line 1 Address line 2 City
State/Province Zip/Postal Code

Group / Program Number --

Employer (if different from above) --

Employer's Address

Secondary Coverage ☐ Yes ☐ No

Dental insurance Company Name ____________________

Dental insurance Address ____________________

Dental insurance Phone Number (201) 555-0123

Subscriber's Name Full Name

Subscriber's ID Subscriber ID

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

Subscriber's Birthday Day Year

Subscriber's Address

Country Address line 1 Address line 2 City
State/Province Zip/Postal Code

Group / Program Number ____________________

Employer (if different from above) ____________________

Employer's Address

____

VI. Release Information

You may discuss my healthcare with

☐ Spouse / Common-law partner

☐ Children

☐ Parents

Others: 1.

VII. Assignment & Release

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 my

insurance submissions whether manual or electronic. I hereby authorize any available insurance benefits to be paid directly to my dentist if he/she accepts such an arrangement.

☐ I confirm that I have read and understood the terms & conditions.

I hereby authorize the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me.

☐ I confirm that I have read and understood the terms & conditions.

______________________________ ____________________

Patient Signature Date

Cedar Dental - Family, Cosmetic and Implant Dentistry
+1 (908) 757-2613 cedardental176@gmail.com

Office Policies

Please Initial Our Financial, Cancellation, & Acknowledgement of Considerate Care Policies

Initials

FINANCIAL AGREEMENT:

I am responsible to pay up front for all of my treatment visits unless prior arrangements have been made. I understand that my dental team is providing me with **ESTIMATES** as close as possible to what insurance is expected to cover, however **I am responsible for payment *regardless* of any insurance company's arbitrary determination of benefits.** I understand no one from my dental office can guarantee payment from my independent third party insurance company.

As a courtesy, my dental office will submit claims to my insurance company on my behalf. I understand that if my insurance company has not made payment within 60 days, I will be asked to contact them myself to make sure payment is expected. I understand if payment is not received or denied I will be responsible for paying the full amount at that time. I understand balances not paid in full within 90 days of the treatment date will receive a **service charge** and be sent to a collections agency.
*All returned checks will be subject $35 fee

Payment Options:
We accept cash, checks, and most major credit cards. We also work with Care Credit so you can get the care you need, when you need it.

Insurance:
We work with and accept all PPO plans.
We are in-network providers for Delta Dental.
We are out-of-network providers for major PPO insurance plans.
If you need assistance, or have questions about your insurance policies or claims, our staff is knowledgeable and always available to help you. Our team can provide you with a complimentary benefits analysis to better understand your coverage in our office. To ensure we are able to provide adequate time with each patient, and the highest quality care, we do not participate with HMO/DMO or Medicaid plans.

SIGNATURE ON FILE

- I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents. I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.
- I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies. authorize payment of health benefits otherwise payable to me, directly to my doctor.

Initials

CANCELLATION POLICY:

I understand that my reservation deposit will be credited back to me if I am unable to complete my treatment visit and sufficient notice is provided. I understand that missing my appointment negatively impacts our practice and other patients who are eager to complete their care. **I understand that if I do not show up for my visit, if I am more than 15 minutes late, or if I cancel without at least 24 hours (business hours) notice , a $50 missed appointment fee will be assessed to my account** and deducted from my reservation deposit. For **Saturday appointments** we require **72 office business hours** notice. I understand repeated failures will result in my dismissal from the practice. While our team understands extenuating circumstances and emergencies do occur, we ask that you call our office as soon as possible so we can clarify any misunderstandings.

Initials

ACKNOWLEDGEMENT OF CONSIDERATE CARE:

I understand my dental team is committed to providing me the highest quality care in the most comfortable environment. I acknowledge that I am entitled to considerate, courteous, and respectful treatment. I understand my dental team will ensure my appointments are scheduled within a timely manner and reasonable accommodations for emergency care will ALWAYS be provided. I understand for the safety and protection of all, security cameras are in use throughout the office iwhich record both visual and audio input. I understand my team complies with all **ADA, CDC, & OSHA regulations** to provide a clean and safe environment for all dental visits. I understand I may seek a second opinion at any time and request a copy of my digital X-rays WITHOUT incurring any additional fees. I understand that I am entitled to **privacy** and **confidentiality** in discussions, examinations, and treatment.

Patient/Guardian Signature: ______________________________

Date: ______________________________

Office Signature: ______________________________

Date: ______________________________