Welcome.

We’re glad you’re here.

We know that going to the dentist may not be at the top of your “to do” list. But whether it’s been six months or six years since your last visit, we’re just glad you’re here.

We promise to listen to your hopes and fears, jitters and concerns. To provide care without pressure, and advice without obligation. To deliver equal doses of care and honesty, because we’re confident you’ll trust us with your mouth when you know we have your best interests at heart.

And we’ll stop at nothing to deliver an experience that is above and beyond what you thought dental care could be.
**Health Information**

We take your oral health very seriously. But before we start your treatment, we need some brief information on your medical history which may affect your treatment. All information is confidential.

Patient’s Name: ___________________________ Date of Birth: __________ Last Physical Date: __________

Physician’s Name & Phone #: ____________________________ Reason for today’s visit? ____________________________

Work Related Injury? (circle) Yes  No  Have you been under the care of a physician? (circle) Yes  No

Have you ever been hospitalized? (circle) Yes  No

Height: ___________________________ Weight: ___________________________

Date of last dental visit: __________ Date of last dental x-rays: __________ Date of last cleaning: __________

Have you ever been treated for periodontal (gum) disease? (circle) Yes  No

Ever had Novocaine or other local anesthetic? (circle) Yes  No

Are you interested in tooth whitening? (circle) Yes  No

If wearing dentures, age of dentures: __________ Are you interested in new dentures? (circle) Yes  No

Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle) Yes  No

Are you taking or have taken Oral Bisphosphonates? (e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, e.g., ZOMETA, AREDIA) (circle) Yes  No  Taken for how long? __________

Have you taken antibiotics prior to dental procedures in the past? (circle) Yes  No

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) Yes  No

List any medications you are allergic to:
1. __________________________ 2. __________________________ 3. __________________________ 4. __________________________

List any medications you are taking including non-prescription drugs and herbals/vitamins:
1. __________________________ 2. __________________________ 3. __________________________ 4. __________________________

<table>
<thead>
<tr>
<th>Do you have a history of:</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatic Fever</td>
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<td></td>
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<tr>
<td>Heart Murmur</td>
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<tr>
<td>Mitral Valve Prolapse</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Veneral Disease</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Low Blood Pressure</td>
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<tr>
<td>Any Type of Transplant</td>
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<tr>
<td>Drug Addiction</td>
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<tr>
<td>Hepatitis (Type:</td>
<td></td>
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<tr>
<td>Liver Disease</td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Women patients only:</td>
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</tbody>
</table>

Is there a possibility of pregnancy?  Are you nursing?  Are you taking any birth control prescriptions?

**NOTE:** Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient’s Signature_________________________ Date __________ Dr’s. Signature/Medical History Review__________________ Date __________

Patient’s Signature_________________________ Date __________ Dr’s. Signature/Medical History Review__________________ Date __________
Address: __________________________________________ City: ___________________________ State: ________ Zip: ________ Home Phone: __________________________ Work Phone: __________________________ Cell Phone: __________________________ Email Address: ____________________________ May we contact you by email? (circle) Yes  No Patient Social Security Number: ___________________________ Patient Date of Birth: ____________ Sex: (circle) M  F Emergency Contact: __________________________ Phone: __________________________ Preferred Pharmacy __________________________ How did you hear about us? ☐ Newspaper  ☐ Radio  ☐ TV  ☐ Internet  ☐ Referral  ☐ Other: __________________________________________

Insurance Information
Do you have Dental Insurance? (circle) Yes  No  Do you have Secondary Dental Insurance? (circle) Yes  No

<table>
<thead>
<tr>
<th>Primary Insured</th>
<th>Secondary Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Name</td>
<td>Subscriber Name</td>
</tr>
<tr>
<td>Subscriber SSN</td>
<td>Subscriber SSN</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Date of Birth</td>
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<tr>
<td>Relationship to Subscriber</td>
<td>Relationship to Subscriber</td>
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<tr>
<td>☐ Self  ☐ Spouse ☐ Child ☐ Other</td>
<td>☐ Self  ☐ Spouse ☐ Child ☐ Other</td>
</tr>
<tr>
<td>Employer Name</td>
<td>Employer Name</td>
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<td>Employer Phone</td>
<td>Employer Phone</td>
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<tr>
<td>Insurance Company</td>
<td>Insurance Company</td>
</tr>
<tr>
<td>Insurance Group #</td>
<td>Insurance Group #</td>
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<tr>
<td>Insurance Phone #</td>
<td>Insurance Phone #</td>
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</tbody>
</table>

*Please present your insurance card to our patient services representative to be photocopied*

Authorization for Release of Health Records to External Parties

I authorize the disclosure of information from my treatment records to:
Name of Recipient: ____________________________
Relationship to the Patient: ____________________________

I give authorization to disclose the following information:
☐ All treatment information
☐ Information specifically related to these treatment dates

Starting Date: ____________________________ End Date: ____________________________

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying my Aspen Dental practice in writing.

Signature of Patient (or Patient Representative) ____________________________ Date: ____________
Printed Name of Patient (or Patient Representative) ____________________________
Financial Policies

At Aspen Dental practices, we are committed to giving you exceptional service and providing treatment that addresses both your short-term and long-term needs. We make it easier for you to get the care you need with our Peace of Mind Promise™, which includes a commitment to everyday low prices, flexible financing options, and no surprises. We also accept a variety of payment options and will work with all insurers. We’re committed to keeping our prices low so that you can get the care you need. We know you have a choice, and we appreciate your decision to trust us with your dental care.

1. A Clear, Written Estimate on the Cost of Treatment

Your dentist will provide you with a comprehensive treatment plan after assessing your overall oral health. We’ll provide a clear, detailed estimate on the cost of your treatment plan in writing so you know what to expect, including your estimated insurance benefits.

If you have any questions related to your insurance coverage, we encourage you to contact your insurance company.

2. Payment Policy

The following payment policies apply:

• Payment in full of the Patient Financial Responsibility amount, as specified in the Treatment Acceptance and Payment Arrangement Form, is due no later than when services are rendered. Acceptable forms of payment include cash, personal checks, Visa®, Master Card®, American Express®, Discover®, assigned insurance benefits and select third-party financing programs.

• For comprehensive treatment plans requiring multiple office visits, a minimum deposit of 60% of the Patient Financial Responsibility amount is required.

• You may, at your discretion, elect to pay in full, in advance for comprehensive treatment plans. Refunds will be processed in accordance with our refund policy.

3. Refund Policy

You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive; provided, however, crown and bridge patients are responsible for the full cost of their treatment plan once preparation of your teeth has begun.

Your refund request will be handled as follows:

• Original Form of Payment. Refunds will be processed to the original form of payment, except cash payments will be refunded by check.

• Seven Days of Inactivity – New Patients. If you are a new patient who has had no treatment performed, has no scheduled appointments and has a credit balance on your account, after seven days of inactivity you will automatically receive either (a) a notice that you are entitled to a refund if you paid by cash or check or (b) an automatic refund to your original form of payment if you paid by credit card or with third party financing.

• 60 Days of Inactivity (*Massachusetts patients see below). Credit balances existing on accounts after 60 days of inactivity will be automatically refunded to the original form of payment, except cash/check payments, which will be notified by letter.
Disclosures

1-866-273-8606 or email us at patientservices@aspendental.com. If you have questions or concerns that cannot be resolved by your office team, please call the Patient Satisfaction Hotline at 1-866-273-8606.

1. A Clear, Written Estimate on the Cost of Treatment

Your Aspen Dental practice accepts payment from non-affiliated, third-party finance companies (i.e., CareCredit issued by Synchrony Bank, DentalFirst Financing, issued by Comenity Capital Bank). The practices pay these companies fees on a sliding scale for making financing available to patients like you and for the finance companies cost of servicing these loans. As the aggregate amount of care financed through these finance companies increases, the fees they charge Aspen Dental practices decrease. This sliding scale pricing arrangement does not affect the amount you finance or the cost of your treatment.

2. Payment Policy

Payment in full of the Patient Financial Responsibility amount, as specified in the Treatment Acceptance and Payment Arrangement Form, is due no later than when services are rendered. Acceptable forms of payment include cash, personal checks, Visa®, MasterCard®, American Express®, Discover®, assigned insurance benefits and select third-party financing programs.

• In Network: If your dentist is a participating provider with your insurance, you will be billed pursuant to the terms of your dentist’s agreement with your insurer.

• Out of Network: If your dentist is not a participating or in-network provider with your insurance plan, we will honor your carriers in network fee structure. If your insurance carrier will not accept your assignment of benefits to your dentist, you are responsible for the estimated insurance benefit.

• Insurance Discounts: Insurance companies often negotiate discounts for services provided to their plan members. Should you exceed your annual benefit limit, the insurer’s discounted rate may apply to additional services as a benefit to you. Aspen Dental practices will honor your insurer’s policy.

3. Refund Policy

Your refund request will be handled as follows:

• Seven Days of Inactivity – New Patients. If you are a new patient who has had no treatment except cash payments will be refunded by check.

• 60 Days of Inactivity (*Massachusetts patients see below). Credit balances existing on accounts after 60 days of inactivity will be automatically refunded to the original form of payment, except cash/check payments will be notified by letter.

• 180 Days of Inactivity (Partial Denture Patients Only). Credit balances existing on accounts after 180 days of inactivity will be automatically refunded to the original form of payment, except cash payments will be refunded by check.

• Timing of Refunds.

  » Cash/Check: After receiving your refund request, we will confirm that your payment has cleared the bank (may take up to 15 business days). Once cleared, you will be issued a refund check within ten (10) business days (five (5) business days for Massachusetts patients).

  » Credit Card/Third Party Financing: Refunds will be issued to the form of payment within three (3) business days after receipt of your refund request. If you paid by credit card, it may take up to seven (7) business days for the credit card company to post the payment to your account.

• How to request a Refund

  » Contact your office and request a refund

  » Email a refund request to: refundrequest@aspendental.com

  » Mail a refund request to:

    Aspen Dental Management, Inc.
    Attn: Refund Processing
    P.O. Box 3126
    Syracuse, NY 13220

    For more information on refunds, please visit: https://www.aspendental.com/pricing-offers#payment-policy

4. Dental Insurance

If you have dental insurance, your insurance claim will be processed as follows:

• In Network: If your dentist is a participating provider with your insurance, you will be billed pursuant to the terms of your dentist’s agreement with your insurer.

• Out of Network: If your dentist is not a participating or in-network provider with your insurance plan, we will honor your carriers in network fee structure. If your insurance carrier will not accept your assignment of benefits to your dentist, you are responsible for the estimated insurance benefit.

• Insurance Discounts: Insurance companies often negotiate discounts for services provided to their plan members. Should you exceed your annual benefit limit, the insurer’s discounted rate may apply to additional services as a benefit to you. Aspen Dental practices will honor your insurer’s policy.

5. Third-Party Financing Disclosure

Your Aspen Dental practice accepts payment from non-affiliated, third-party finance companies (i.e., CareCredit issued by Synchrony Bank, DentalFirst Financing, issued by Comenity Capital Bank). The practices pay these companies fees on a sliding scale for making financing available to patients like you and for the finance companies cost of servicing these loans. As the aggregate amount of care financed through these finance companies increases, the fees they charge Aspen Dental practices decrease. This sliding scale pricing arrangement does not affect the amount you finance or the cost of your treatment.
Credit decisions are solely the responsibility of these third-party finance companies. You may elect to pay all or a portion of your treatment using one of these third-party financing products.

6. Patient Satisfaction Inquiries

We are committed to providing you with exceptional service and care. If you feel you have an issue that cannot be resolved by your office team, please call the Patient Satisfaction Hotline at 1-866-273-8606 or email us at patientservices@aspendental.com.
Receipt of Treatment Plan & Financial Policies

1. Payment, Insurance, and Financial Arrangement Policies (must be signed by ALL new patients).

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature_____________________________________________Date________________________

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

2. Notice of Privacy Practices (must be signed by ALL new patients).

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Signature_____________________________________________Date________________________

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

3. Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance).

To the extent permitted by law, I consent to my practice (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature_____________________________________________Date________________________

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

4. Consent to obtain patient medication history.

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/ HIV and medicines used to treat mental health issues.

Signature_____________________________________________Date________________________

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

Responsible Party (If patient is under 18 or disabled)

Circle One: Dr/Mr/Mrs/Ms/Miss

First:_____________________Middle:______________Last:______________________________Jr/Sr:______

Street: ___________________________________City:_____________________State: ______Zip: _________

Home Phone: (____) ________________Work Phone:(____) ____________Cell Phone:(____) ____________

Patient SSN: ________-_______-________Patient Date of Birth: _____/_____/_____Sex:(circle) M F

Signature:____________________________________________________________Date:__________________

*Retain Original in Patient’s Chart
About ADMI

There is no single provider of dental care called “Aspen Dental”. Aspen Dental Management, Inc. (“ADMI”) provides administrative and business support services to dental practices that are independently owned and operated by licensed dentists. ADMI licenses the “Aspen Dental” brand name to the independently owned and operated dental practices that use its business support services. ADMI does not own or operate the dental practices, employ or in any way supervise the dentists providing dental care, and control over the care provided is the sole responsibility of the independent practice and the dentists they employ. Services and office practices may vary across dental practices, and patients should contact the dental offices directly for all questions concerning their dental treatment.

West Virginia/Missouri

Retain Original in Patient’s Chart

Disclosure Pursuant to:

- W. Va. CSR § 5-8-4.5

Your Aspen Dental practice may, from time to time, provide offers containing free services to some or all of its patients. If you received a free service, you have the right to refuse to pay or to demand reimbursement for any other services provided to you within 72 hours of the free service unless you request the additional service(s) at the time the free offer is provided. Please read the following acknowledgement and sign where indicated (if the statement is true).

I hereby acknowledge that I have received a free service, examination or treatment, and further acknowledge that I am requesting additional service(s) to be provided to me at the time of the free service, examination or treatment, as provided in the documentation provided to me after my examination.

Signature____________________________________Date________________________