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 effect 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)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Have you ever been hospitalized? (circle)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**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)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Have you ever had Novocaine or other local anesthetic? (circle)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Are you interested in tooth whitening? (circle)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**If wearing dentures, age of dentures:** ____________ **Are you interested in new dentures? (circle)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Are you taking or have taken any steroid/cortisone therapy in the last 2 years? (circle)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Are you taking or have taken Oral Bisphosphonates? (e.g., FOSAMAX, ACTONEL, BONIVA, or IV Bisphosphonates, (e.g., ZOMETA, AREDIA) (circle)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Taken for how long? __________________________**

**Have you taken antibiotics prior to dental procedures in the past? (circle)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle)**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Is there a possibility of pregnancy? Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you nursing?</td>
<td></td>
</tr>
</tbody>
</table>

**Estimated Delivery Date:** / /

<table>
<thead>
<tr>
<th>Are you taking any birth control prescriptions? Y</th>
<th>N</th>
</tr>
</thead>
</table>

**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 Information

Please Print

Circle One: Dr/Mr/Mrs/Ms/Miss
First: _____________________________ Middle: __________________________ Last: __________________________ Jr/Sr: _______
Street: __________________________ 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>
</tr>
<tr>
<td>Relationship to Subscriber</td>
<td>Relationship to Subscriber</td>
</tr>
<tr>
<td>☐ Self  ☐ Spouse  ☐ Child  ☐ Other</td>
<td></td>
</tr>
<tr>
<td>☐ Self  ☐ Spouse  ☐ Child  ☐ Other</td>
<td></td>
</tr>
<tr>
<td>Employer Name</td>
<td>Employer Name</td>
</tr>
<tr>
<td>Employer Phone</td>
<td>Employer Phone</td>
</tr>
<tr>
<td>Insurance Company</td>
<td>Insurance Company</td>
</tr>
<tr>
<td>Insurance Group #</td>
<td>Insurance Group #</td>
</tr>
<tr>
<td>Insurance Phone #</td>
<td>Insurance Phone #</td>
</tr>
</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.
Massachusetts patients. Credit balances existing on accounts after 45 days of last deposit with no future appointment will be automatically refunded to the original form of payment, except cash/check payments will be notified by letter. Credit balances existing on accounts of denture patients after 45 days of inactivity will be automatically refunded to the original form of payment, except cash/check payments, which 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.

• 7 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, which will be notified by letter.

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.
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.
Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review carefully. The privacy of your health information is important to us.

Our Legal Duty
Your Aspen Dental practice ("we", "our", "us"), like all other medical and dental practices, is 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 went into effect April 14, 2003, with the latest revision August 20, 2013 and will remain in effect until modified or replaced. 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 according to the means outlined in 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/dentist, dental auxiliaries, students and 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 prescriptions, dental supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We may use Patient Information internally to offer goods and services we believe may be of interest. We may use Patient Information to contact you to inquire or survey about the
Patient experience at the location(s) visited and the prospect of future services or improvements needed to continue as your services provider. We may also create and use aggregate Patient Information that is not personally identifiable to understand more about the common traits and interests of our Patients.

We may utilize one or more third-party service providers to send email or other communications to you on our behalf, including Patient satisfaction surveys. These service providers are prohibited from using your email address or other contact information for any purpose other than to send communications on our behalf.

It is our intention to only send email communications that would be useful to you and that you want to receive. When you provide us with your email address as part of the registration or appointment setting process, we will place you on our list of patients to receive informational and promotional emails. In addition, patients and visitors to our website are given the opportunity to “opt-in” to receive electronic promotional communications by selecting the option to receive promotional email from us on our website. Each time you receive a promotional email, you will be provided the choice to “opt-out” of future emails by following the instructions provided in the email or you can “opt-out” at any time by following the instruction provided.

Cookies

Our website utilizes “cookie” technology. “Cookies” are encrypted strings of text that a website stores on a user’s computer. Our website uses cookies throughout the online process to keep together information entered on multiple pages. For example, cookies enable our website to “remember” information provided to us.

In addition, cookies are used to:

1. Measure usage of various pages on our website to help us make our information more pertinent to your needs and easy for you to access; and,

2. Provide functionality such as online appointing, bill paying and other functionality that we believe would be of interest and value to you.

The two types of cookies that we use are referred to as “session” cookies and “persistent” cookies. Session cookies are temporary and are automatically deleted once you leave our website. Persistent cookies remain on your computer hard drive until you delete them. We do not use cookies to gather any personally identifiable information about you apart from what you voluntarily provide us in your dealings with us. Our cookies do not corrupt or damage your computer, programs or computer files. You may set your browser to block cookies.

Fund Raising: We will not use your health information for fund raising activities without your written consent.

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 practicably do so.
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). When you pay in full outside of your insurance plan for services you may request that we restrict this information and not disclose it to your healthcare plan or insurer.

Breach Notification: We will provide you with notification of a breach of unsecured PHI as required by law.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be 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. This 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 received this notice on our Web site or by electronic mail (e-mail), you are also entitled to receive this notice in written form.

Questions and Concerns

If you would like additional information about our privacy practices or have questions, Aspen Dental’s HIPAA Compliance Officer may be reached at 800-996-6470 extension 1250.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or our handling of your 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 send your concerns to Aspen Dental, Attn: HIPAA Compliance Officer 281 Sanders Creek Parkway East Syracuse, NY 13057. You also may submit written concerns to the U.S. Department of Health and Human Services. We will provide you with the address to the U.S. Department of Health and Human Services upon request.

We support your right to maintain 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.
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
Disclosures

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________________________