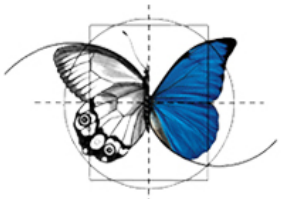

Dental Implant Partners

Dental Implant Partners
450 Sutter Street #2536,
San Francisco 94108
Ph |415-391-5207
Fx |415-362-2412

Welcome to Dental Implant Partners, the offices of Belinda Gregory-Head DDS, MS and Alex McDonald PhD, DDS providing the best in preventative, restorative and cosmetic dentistry.

The forms included in this package all need to be completed before your treatment, it's best to fill them out before you come, as this will expedite your appointment. Completed forms can also be faxed to us if you like, our fax number is 415-362-2412. If you need assistance, please call our office during business hours Monday - Thursday 8am-5pm at 415-391-5207.

We require a patient information form that includes your primary and secondary insurance information if any, and a medical history. There are pages that describe privacy practices, information about insurance and payment options and our office policy regarding cancellations. There is also a release form regarding photographs that may be taken before, during and after your course of treatment. Don't hesitate to call if you have questions or need explanations, we are here to help.

There is a separate information sheet that can be downloaded from our site that details our location; it includes parking, public transportation and a map to help you find us.

We look forward to your visit!

Dental Implant Partners 450 Sutter Street #2536, San Francisco 94108 Ph /415-391-5207 Fx /415-362-2412

PATIENT REGISTRATION

ID:_____ Chart ID:_____

First Name:_____ Last Name:_____ Middle Initial:_____

Patient is: ☐ Policy Holder Preferred Name:_____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____ Address 2:_____

City, State, Zip:_____ Pager:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____

Birth Date: _____ Soc. Sec: _____ Driver's Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address:_____ Address 2:_____

City, State, Zip:_____ Pager:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowec

Birth Date: _____ Age:_____ Soc. Sec: _____ Driver's Lic: _____

E-mail:_____ ☐ I would like to receive correspondences via e-mail

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Section 3

Cell Phone #:_____

Emergency Phone #:_____

Thank Referral Y/N?:_____

Patient Preferences – Correspondence

◯ Email ◯ Phone: ◯ Before Noon ◯ After Noon ◯ After 5pm

Primary Insurance Information

Name of Insured:_____ Relationship to Patient ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec:_____ Insured Birth Date: _____

Employer:_____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone #: _____ Phone #: _____

Rem. Benefits:_____.00 Rem. Deduct:_____.00

Secondary Insurance Information

Name of Insured:_____ Relationship to Patient ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec:_____ Insured Birth Date: _____

Employer:_____ Insurance Company: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone #: _____ Phone #: _____

Rem. Benefits:_____.00 Rem. Deduct:_____.00

To the best of my knowledge, the questions on this form have been accurately answered.

SIGNATURE OF PATIENT, PARENT or GUARDIAN_____ DATE_____

Dental Implant Partners 450 Sutter Street #2536, San Francisco 94108 Ph /415-391-5207 Fx /415-362-2412

MEDICAL HISTORY

Patient Name:_____ Birth Date:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain:_____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain:_____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain:_____

Are you taking any medications, pills or drugs? ◯ Yes ◯ No If yes, please explain:_____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain:_____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

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

Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN_____ DATE_____

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.
As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your medical information.
We may use and disclose you medical records only for each of the following purposes: treatment, payment and health care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.
We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of your protected health information.

• The right to obtain a paper copy of this notice from us upon request.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dental Implant Partners
450 Sutter Street # 2536
San Francisco 94108
National Provider Identifier #1710180948

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third party payers.

• Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices (attached) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing an explanation of how you restrict the use and disclosure of my private information to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if this organization does agree, then this organization is bound to abide by such restrictions.

Patient Name _____

Signature _____

Relationship to _____

Patient _____

Date _____

DENTAL "BENEFITS" ACKNOWLEDGEMENT

It is our goal to provide the best dentistry for you. In order to do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based on your needs, and we assume that you are as concerned as we are about maintaining your good health.

The term "dental insurance" is misleading. What is commonly known as "dental insurance" is more correctly termed dental "supplement". Dental benefits are not intended to pay everything, but to assist with the costs of dental treatment. Generally, dental benefits pay a percentage of each procedure up to a set yearly maximum. The benefits available to you are established by which plan package your employer has purchased, and it is possible your employer may change your benefits package at will without notifying our office. To avoid confusion, we recommend that you call your insurance carrier on the day prior to having any dental treatment to ensure eligibility and that the dental treatment estimate presented by our office is consistent with your employer's most current benefit package. Please let our office know if we need to be aware of any inconsistencies.

As a courtesy to you, we will submit claims to your dental plan carrier. We also accept benefit assignment, meaning that we will estimate expected benefit payment and allow you to pay your estimated portion at the time services are provided. However, we do not guarantee an estimate and should your dental plan pay less than expected, you are fully responsible for the balance. We cannot take responsibility for any denial by your dental plan(s).

We value you and your family as patients and friends. We strive to do our very best in accurately estimating your patient portion responsibility, however, your dental health is our first concern. We welcome any comments or feedback on how we can better assist you.

I have read the above information and understand that I am responsible for familiarizing myself with all aspects of my benefits. I also understand that I am responsible for charges not covered by my plan.

Patient Name _____

Signature _____

Relationship to _____

Patient _____

Date _____

OUR OFFICE POLICY

Thank you for choosing Dental Implant Partners as your dental provider. In order to make our relationship work more effectively, we would like to make you aware of our office policy.
While we very much value our patients, failure to keep scheduled appointments may result in a $75 charge. Our cancellation policy requires a telephone call at least two business days (48 hours) prior to scheduled appointments to avoid a cancellation charge. If you need to cancel or reschedule please call ou office at 415-391-5207 Monday - Thursday 8 am – 5 pm.
Please be advised our office is closed on Friday so Monday appointments must be cancelled no later than Thursday to avoid a cancellation charge.

Payments for dental services are due in full on the day of your dental appointment, unless other arrangements are made in advance.

We accept Cash, Checks, Visa, MasterCard or Debit Card.

For those patients who have dental insurance, we are happy to process your claims for maximum reimbursement. However, any portion that is not covered by insurance is due on the day of your appointment unless other arrangements have been made in advance. Please let us know if you have any questions regarding our office policy.

I have read and understand the office policy as outlined above. I understand my financial responsibility.

Patient Name _____

Signature _____

Relationship to _____

Patient _____

Date _____

Photograph Authorization

I hereby give my consent for Dental Implant Partners / Dr. Belinda Head, Dr. Alex McDonald to take photographs, slides and/or videotape of [patient's name]_____ face, jaw, and teeth. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, or advertisements to promote cosmetic dentistry.

I understand that some of these images may be used by laboratories for fabrication of crowns, veneers, bridges, or dentures and these images will become part of my dental record.

I do not expect compensation, financial or otherwise, for the use of these images. Please initial: _____

- I consent to the use of my photographs, slides, and/or videotape for articles, lectures, marketing, advertising, and laboratory use.
- I consent to the use of my photographs, slides, and/or videotape ONLY for laboratory use.
- I DO NOT consent to the use of my photographs, slides, and/or videotape.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization. Unless revoked by me, this authorization expires 10 years from the date I sign below.

Patient Name _____

Signature _____

Relationship to _____

Patient _____

Date _____