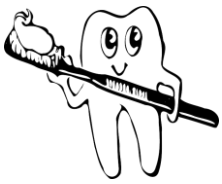


Penacook Family Dentistry

Patient Information

Thank you for choosing Penacook Family Dentistry. Please complete this form. If you have any questions, do not hesitate to ask for assistance!

First Name: _____ M.I. _____ Last Name: _____

Preferred Name: _____ Birth Date: _____ Age: _____

Mailing Address: _____City: _____ State: ____ Zip: _____

Home Phone: _____Cell: _____ Email: _____

Emergency Contact: _____ Relation: _____ Phone #:_____

How did you hear about Penacook Family Dentistry? If you were referred, by whom? _____

_____

Insurance Information

Name of subscriber: _____ Patient's relationship to subscriber: _Self _Spouse _Child

Birthday: _____ Social Security #: _____

Name of Employer: _____ Insurance Co: _____

Group #: _____ ID#_____

Dental Claims Mailing Address: _____

Dental History

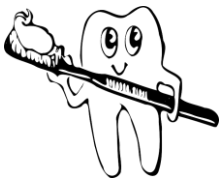
Former Dentist: _____

Reason for today's visit: _____

Date of last exam?: _____ Date of last X-ray's?: _____

Primary Care Physician Information

Physician: _____ Date of last visit: _____ Phone #:_____



Penacook Family Dentistry

Medical History

Please list all medications you are currently taking: _____

_____

Have you ever been advised to take a premedication prior to dental procedures?: _____

Do you have artificial joints, screws, plates, or breast augmentation?: _____

IF yes, location?: _____

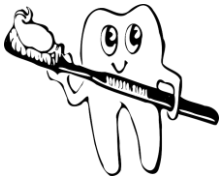
(Women) Are you pregnant? _Yes or _No Nursing? _Yes or _No Taking Birth Control Pills? _Yes or _No

Any history or current Tobacco use? If so, what kinds, how much, and how long? _____

Unusual reaction to dental injections? _____

Do you have a history of the following?

_ Abnormal Bleeding	_Congenital Heart	_Heart Surgery	_Radiation Therapy
_ Alcohol Abuse	_Diabetes	_Hemophilia	_Rheumatic Fever
_Allergies	_Difficulty Breathing	_Hepatitis A	_Seizures
_Anemia	_Drug Abuse	_Hepatitis B	_Shingles
_Angina Pectoris	_Emphysema	_High Blood Pressure	_Sickle Cell Disease
_Arthritis	_Epilepsy	_HIV+AIDS	_Sinus Problems
_Artificial Bones	_Fainting Spells	_Kidney Problem	_Stroke
_Artificial Heart	_Fever Blisters	_Liver Disease	_Thyroid Problems
_Asthma	_Frequent Headaches	_Low Blood Pressure	_Total Joint Replacement
_Blood Transfusion	_Glaucoma	_Mitral Valve	_Tuberculosis
_Cancer-Chemotherapy	_Hay Fever	_Pace Maker	_Ulcers
_Colitis	_Heart Attack	_Psychiatric Problems	_Venereal Disease
	_Heart Murmur		_Yellow Jaundice



Penacook Family Dentistry

PLEASE READ COMPLETELY AND SIGN
POLICY REGARDING MISSED APPOINTMENTS, SAME -DAY CANCELLATIONS & LATE ARRIVALS

MISSED APPOINTMENT- Twenty-four (24) hours notice is required prior to the appointment to let us know that you will not be keeping your appointment. ***Please note that a Same-Day Cancellation constitutes a missed appointment.*** You can call our office at (603) 753-6371 to cancel or reschedule your appointment. You may always leave a message on our answering machine if you need to call outside of the routine business hours. After two (2) missed appointments, you will receive written notification in the mail. Any missed appointments after written notification will result in a $100.00 missed appointment fee. The fourth (4) may result in dismissal from our practice due to lack of compliance.

LATE ARRIVALS- Please note that if you arrive more than fifteen (15) minutes late for an appointment, it will be considered a missed appointment. If time does not permit, you may be asked to reschedule to a different time. Please call the office at (603) 753-6371 if you are going to be late to determine if you can still be seen or if we need to reschedule your appointment.

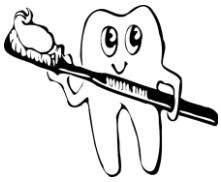
PAYMENT POLICY

✶ **CO-PAY-** Your **estimated** co-payment will be collected at the time of the office visit. Any remaining balance is the patient's responsibility, and will be billed to you after the insurance claim has been processed.

✶ **SELF-PAY-** Full payment is due at the time of the office visit.

Patient/Guarantor Name:_____

Signature: _____Date:_____



Penacook Family Dentistry

You May Refuse to Sign This Acknowledgement

I have reviewed a copy of the Notice of Privacy Practices for this office.

Print patient name: _____ DOB**:** _____

Signature of patient or representative: _____

Relationship to patient if signing as a representative: _____

I hereby authorize the following person or people to access my treatment information, billing information, and grant them the right to schedule or change appointments on my behalf.
(Please Print)

Name: _____ Relationship**:** _____

Phone number: _____

Name: _____ Relationship: _____

Phone number: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining a signature
- An emergency situation prevented us from obtaining a signature
- Other (Please specify)

Soheila Degieux, D.D.S INC

Notice of Privacy Practice

This notice describes how health information about you may be used or disclosed. The privacy of your health information is important to us at Penacook Family Dentistry.

Our Legal Duty

We are required by applicable laws to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, and your rights concerning your health information. This notice takes effect on April 14, 2003 and will remain in effect until we replace it. We reserve the right to change 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 any additional information or for additional copies of this notice, please contact the office.

Uses and Disclosures of Health Information

As mentioned, we may need to disclose health information about you for treatment, payments and healthcare operations under the following guidelines.

Treatment: We may need to use or disclose your health information to another dentist, physician or any other healthcare provider providing treatment for you.

Payment: We may use or disclose your health information to obtain payment for services we provide for you.

Healthcare Operations: We may use or disclose your health information in connection with our usual office healthcare operations.

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 care information or disclose it to anyone for any purpose. You may also revoke this authorization, in writing at any time. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree, in writing, that we may do so.

Persons Involved in Your Care: We may use or disclose your health information to assist in notification of a family member, your personal representative, or another person responsible for your care, your general condition or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using professional judgment, disclosing only health information that is directly relevant to the person's involvement in your health care.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when required by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities to the extent necessary to avert a serious threat to your health or safety (suspect neglect, abuse, domestic violence or other crimes.)

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, e-mail, postcards or letters)

Patient Rights

You have the right to look at or obtain copies of your health information, with limited exceptions, upon request in writing or on a form available. A reasonable charge can be made for the above to compensate for copies, staff time and mailing expenses, if applicable.

You have the right to request that we place additional restrictions on our use of disclosure or 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 any emergency).

We support your right to the privacy of your health information and will protect that information to the best of our ability.