As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature: __________________________ Date: ________________

Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (Please Print Name) ________________________________, have received a copy of this office’s Notice of Privacy Practices.

(Signature) ____________________________________________________________________
(Date) _________________________________________________________________________

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:

1 - Individual refused to sign
1 - Communication barriers prohibited obtaining the acknowledgement
1 - An emergency situation prevented us from obtaining acknowledgement
1 - Other (Please Specify) __________________________________________________________

PERMISSION TO SHARE INFORMATION ACKNOWLEDGMENT

I, (Please Print Name) ________________________________, give Borden Dental Arts permission to share information concerning my dental care with:

1. _________________________________________________________________________
   Name ________________________________ relationship to patient

2. _________________________________________________________________________
   Name ________________________________ relationship to patient
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?
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
</tr>
</thead>
</table>

### Have you ever been hospitalized or had a major operation?
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
</tr>
</thead>
</table>

### Have you ever had a serious head or neck injury?
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
</tr>
</thead>
</table>

### Are you taking any medications, pills, or drugs?
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
</tr>
</thead>
</table>

### Do you take, or have you taken, Phen-Fen or Redux?
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
</tr>
</thead>
</table>

### Have you ever taken Fosamex, Boniva, Actonel or any other medications containing bisphosphonates?
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
</tr>
</thead>
</table>

### Are you on a special diet?
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### Do you use tobacco?
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### Do you use controlled substances?
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
</tr>
</thead>
</table>

#### Women: Are you...
- **Pregnant/Trying to get pregnant?**
- **Nursing?**
- **Taking oral contraceptives?**

### Are you allergic to any of the following?
<table>
<thead>
<tr>
<th></th>
<th>Aspirin</th>
<th>Penicillin</th>
<th>Codeine</th>
<th>Acrylic</th>
<th>Local Anesthetics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Do you have, or have you had, any of the following?
<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
</tr>
</thead>
</table>

- **AIDS/HIV Positive**
- **AIDS/HIV Positive**
- **Diabetes**
- **Drug Addiction**
- **Easy Blinding**
- **Emphysema**
- **Epiliepsy or Seizures**
- **Excessive Bleeding**
- **Excessive Thrust**
- **Fainting Spells/Blackouts**
- **Frequent Cough**
- **Frequent Diarrhea**
- **Frequent Headaches**
- **Gastro-Esophageal Reflux Disease**
- **Gastro-Intestinal**
- **Heart Attack/Failure**
- **Heart Murmur**
- **Heart Pacemaker**
- **Heart Trouble/Disease**
- **Hemophilia**
- **Hepatitis A**
- **Hepatitis B or C**
- **Herpes**
- **High Blood Pressure**
- **High Cholesterol**
- **Hives or Rash**
- **Hypoglycemia**
- **Hypothyroidism**
- **Irregular Heartbeat**
- **Kidney Problems**
- **Leukemia**
- **Liver Disease**
- **Lung Disease**
- **Malignant Tumor**
- **Mental Illness**
- **Mental Disorders**
- **Mental Retardation**
- **Mental Retardation**
- **Multiple Sclerosis**
- **Muscular Dystrophy**
- **Neurological Disease**
- **Nosebleeds**
- **Obstructive Sleep Apnea**
- **Pain in Jaw Joints**
- **Parathyroid Disease**
- **Psychiatric Care**
- **Radiation Treatments**
- **Recent Weight Loss**
- **Renal Dialysis**
- **Rheumatic Fever**
- **Rheumatism**
- **Sickle Cell Disease**
- **Sickle Cell Syndromes**
- **Sinus Trouble**
- **Sleep Apnea**
- **Spina Bifida**
- **Stomach/Gastrointestinal Disease**
- **Stroke**
- **Surgery**
- **Swelling of Limbs**
- **Tuberculosis**
- **Tumors or Growth**
- **Ulcers**
- **Vascular Disease**
- **Videoblast**
- **Veneered Disease**

- **Other:**

### Have you ever had any serious illness not listed above?
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>If yes</th>
</tr>
</thead>
</table>

### 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:

X

Date:__________