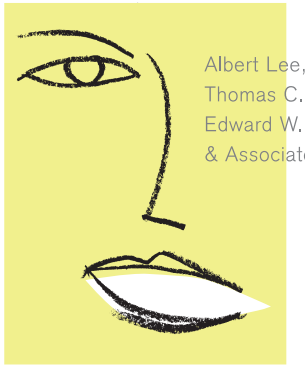

Albert Lee, D.D.S.
Thomas C. Bonfiglio, D.D.S.
Edward W. Vesely, D.M.D.
& Associates

COSMETIC & IMPLANT
DENTISTRY

Date _____

PATIENT REGISTRATION

Patient Name _____
(first) (middle) (last)
Preferred Name or Nickname _____
Birth Date _____ Sex M F Marital Status S M D
Address _____ Apt# _____
City _____ State _____ Zip Code _____
Home Phone (____) _____ Work Phone (____) _____ Cell or Other (____) _____
SS# _____ E-mail Address _____
Would you like to receive e-mail appointment reminders? Y or N
Employer's Name _____ Occupation _____
Employer's Address _____ Full Time Student Y N Grade _____
Has any member of your family ever been treated in our office? Y or N
Whom may we thank for referring you to our office? _____

PERSON RESPONSIBLE FOR THIS ACCOUNT (if different from above)

Relationship to Patient ( ) Spouse ( ) Parent/Guardian ( ) Other _____
Name _____ Birth Date _____ Sex M F
Does this person reside in the same household? Y or N
Address _____ Apt# _____
City _____ State _____ Zip Code _____
Home Phone (____) _____ Work Phone (____) _____ Cell or Other (____) _____
SS# _____ E-mail Address _____

IS THE PATIENT COVERED BY DENTAL INSURANCE? ( ) Yes ( ) No

If no, skip to next page

Insurance Company Name _____ Group# _____
Claims mailing address _____
Phone (____) _____
Policyholder's Name _____ Birthdate _____ Sex M F
Policyholder's SS# _____
Policyholder's ID# _____
Policyholder's Address (if different from patient) _____
City _____ State _____ Zip Code _____
Employer's Name _____
Employer's Address _____
Relationship to Patient ( ) Self ( ) Spouse ( ) Parent/Guardian

DOES PATIENT HAVE SECONDARY DENTAL INSURANCE? ( ) Yes ( ) No

Insurance Company Name _____Group# _____
Claims mailing address_____
Phone (____) _____
Policyholder's Name _____Birthdate _____ Sex M F
Policyholder's SS#_____
Policyholder's Address (if different from patient)_____
City _____ State _____Zip Code _____
Employer's Name _____
Employer's Address_____
Relationship to Patient ( ) Self ( ) Spouse ( ) Parent/Guardian

PERSON TO CONTACT IN CASE OF EMERGENCY

(Outside of immediate family/household)

Name_____
Address _____
City _____State_____ Zip Code _____
Home Phone (____)_____ Cell or Other (____) _____

TREATMENT AUTHORIZATION

I hereby authorize the office of Drs. Lee, Bonfiglio, Vesely and Associates to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I also understand it is very important to report any changes in my medical or dental status to my provider at the earliest possible time, and I agree to do so.

Signature _____ Date _____

PAYMENT AUTHORIZATION

I hereby authorize payment directly to Drs. Lee, Bonfiglio, Vesely and Associates of the group insurance benefits otherwise payable to me. Due to the constantly changing insurance rules and regulations, benefits and deductibles, the Dental Office is only able to approximate your out-of-pocket expenses for dental treatment. Your dental insurance benefits are based upon a contract between you or your employer and the insurance company, not our office. If your insurance pays more than expected you will be credited the difference. I understand that if payments are not received by the agreed upon dates, a finance charge may be added to my account after 90 days of the date of service in addition to any collection charges. I authorize the use of my social security number to file my dental claim and understand that if one is not provided to the office, payment in full will be expected at every visit. It is important for you to understand that you are personally responsible for all charges that you incur in this office. I understand and accept final responsibility for all costs incurred.

Signature _____ Date _____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability of 1996 (**HIPAA**). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name:_____ Date: _____

Signatures:_____

Relationship to Patient:_____

Dependent family members also covered by this acknowledgment:

_____

_____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ❏ The patient refused to sign
- ❏ Communication barriers
- ❏ Emergency situation
- ❏ Other _____

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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ 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? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 _____