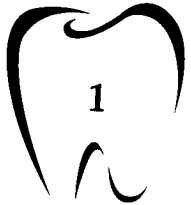


WELCOME

to ERRINGER FAMILY DENTAL GROUP
1755 Erringer Road, Suite 21 • Simi Valley, CA 93065
(805) 522-7370 • Fax: (805) 522-2780

ABOUT YOU



Today's Date:

_____ Month _____ Day _____ Year

Social Security #:

Name: _____
Last First Middle Initial

I like to be called: _____

Home Address: _____

Apt./Condo # City State Zip Code

Mailing address, if different:

Address: _____

City State Zip Code

Your Employer: _____

Occupation: _____

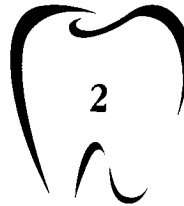
Birthdate: _____ Male Female
Month Day Year

Single Married Divorced Widowed

Special interests, sports or hobbies: _____

Referred by: _____

DENTAL INSURANCE



Do you have dental insurance through your employer? Yes No

If yes, please provide the following information:

Dental Insurance Co. #1: _____

Group #: _____

Insurance Co. Phone #: _____

Your Employer's Name: _____

Do you have any other Dental Insurance Coverage? Yes No

This coverage is through: Spouse Parent Other: _____

Their Name: _____

Their Employer's Name: _____

Their Social Security #: _____

Their Birthdate: _____
Month Day Year

Dental Ins. Co. #2: _____

Group #: _____

Ins. Co. Phone #: _____



TELEPHONE

Home Phone: _____

Work Phone: _____ Ext #: _____

Beeper or car phone: _____

When is the best time to reach you? _____

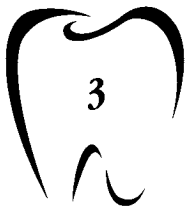
Where? _____ Specific days? _____

In the event of an emergency, is there someone who lives near you that we could contact?

Name _____ Address: _____

Relationship: _____ Work #: _____ Home #: _____

MEDICAL HISTORY



Do you have a personal physician? Y N
 Their name: _____
 Their phone: _____
 The approximate date of your last
 doctors visit: _____

Your current physical health is: Good Fair Poor
 Are you currently under the care of any physician? Yes No
 If yes, please explain: _____
 Do you smoke or use tobacco in any other form? Yes No
 Are you presently taking any drugs prescribed by a physician or
 dentist? Yes No If yes, please list: _____

For women: Are you pregnant? No Yes, Wk. # _____

Do you need to be premedicated before dental treatment? Yes No

Have you had any serious medical problems in the last 5 years?
 Yes No If yes, please explain: _____

Have you ever had any of the following diseases or medical problems?

- | | |
|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack/Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Chemotherapy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur/Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+/AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery/Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N High/Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters |
| <input type="checkbox"/> Y <input type="checkbox"/> N Severe Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures/Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Drug/Alcohol Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease |

OFFICE USE ONLY Doctor's comments: _____

Any other serious medical conditions:

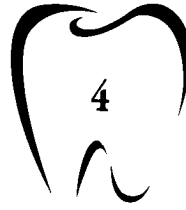
Have you experienced any that are not listed above? Yes No
 If yes, please list: _____

Are you allergic to any of the following drugs?

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin | <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Codeine |

Are you allergic to any other drugs? Yes No
 If yes, please list: _____

DENTAL HISTORY



Previous Dentist
 Their Name: _____
 Their Phone: _____
 Are you currently in pain? Yes No

Are you under any unusual stress at home or work? Yes No
 Do you experience stress or anxiety when you visit a
 dental office? Yes No
 The approximate date of your last dental visit: _____

Have you ever experienced TMJ problems? Yes No
 (TMJ is pain or discomfort in your jaw joints.)

Do you grind your teeth? Yes No
 Your current dental health is: Good Fair Poor
 Do you like your smile? Yes No
 Do your gums ever bleed? Yes No
 Would you like to prevent dentures? Yes No

Do you have or do you use any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Teeth Sensitive to Cold,
Heat, Sweets or Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Pain Around Ear
Unpleasant Taste |
| <input type="checkbox"/> Y <input type="checkbox"/> N Swelling or Lumps in Mouth | <input type="checkbox"/> Y <input type="checkbox"/> N Dental Floss |
| <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal Treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Unusual Sounds in Ear
While Eating |
| <input type="checkbox"/> Y <input type="checkbox"/> N Oral habits, i.e., fingernail
biting, cheek biting, etc. | <input type="checkbox"/> Y <input type="checkbox"/> N Unfavorable Dental
Experience |
| <input type="checkbox"/> Y <input type="checkbox"/> N Texture of toothbrush _____ | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequency of brushing _____ | |



I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Erringer Family Dental Group

GENERAL AND COSMETIC DENTISTRY

1755 ERRINGER ROAD, SUITE 21
SIMI VALLEY, CA 93065
(805) 522-7370

Insurance figures are ESTIMATES ONLY !! It is not easy for an office to become familiar with the details of every dental plan it encounters. It is the responsibility of the patient, NOT the dental office employees, to know what is covered and what is excluded from their particular dental plan. Certain dental plans require predetermination for specific procedures or when charges are expected to exceed a certain amount. All dental offices and insurance companies are required to follow a set of procedure codes setup by the American Dental Association to describe a specific dental procedure. The existence of a dental procedure code cannot guarantee coverage by the insurance carrier.

Although we strive to give our patients the best quality of care, our office does appreciate your assistance with any matters that pertain to your insurance coverage.

I understand that I am responsible for any amounts that are not paid by my dental plan.

Patient signature

Please print name

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

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:

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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are 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 takes effect April 14, 2003, and will remain in effect until we replace it.

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 using the information listed at the end of 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 or 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 filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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 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. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.25 for each page, \$ 20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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).

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

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in 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 complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to 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.

Contact Officer: Erringer Family Dental Group

Telephone: (805)522-7370

Fax: (805)522-2780

E-mail: _____

Address: 1755 Erringer Rd Suite 21. Simi Valley, CA 93065