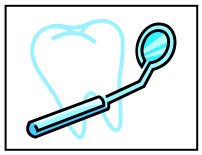
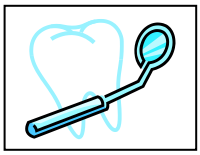


Dental Design Innovations

Dr. Joseph M. Skladany

10 Memorial Drive, Pinehurst (910)215-4554



Patient Information

Patient Name: _____ Date: _____
Last First MI

☐Male ☐Female ☐ Married ☐ Single ☐ Child ☐ Other ____

Birth Date: _____

Phone (Home): _____(Work):_____Ext:_____ Cell:_____

Email address: _____Text #:_____

Address: _____
Street Apartment#

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? _____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

Birth Date:_____

Phone (Home):_____(Work):_____Ext:_____Best time to call:_____

Address:_____
Street Apartment#

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Occupation:_____

Address:_____ Phone #:_____

Insurance Information

Primary

Name of insured:_____ Relationship to patient?_____
Last First MI

Insured's Birth Date:_____ ID/SS #:_____ Group #:_____

Insured's Employer Name:_____

Health Information

- Are you allergic to any medications? ___yes ___no If yes, please list with reaction:
  _____
  _____
- Have you ever been told you need to pre-medicate before your dental visit? ___ yes ___no
  If yes, please list reason: _____
- History of surgeries: _____
- Name of Physician: _____
- Name of Pharmacy: _____
- Do you have any health problems that need further clarification? ___yes ___no
  If yes, please explain:_____
- In case of emergency, please notify:
  _____
  Name Phone #

Health Information

Please list any medications you are taking. (If you have a written list please give it to the receptionist)

Have you been hospitalized in the last 5 years or have there been any changes in your Medical History?

Have you ever had any of the following? Please check those that apply.

__ Allergy-Codeine
__Allergy-Penicillin
__Anxiety/Depression
__Bleeding Risk
__Cancer
__Dizziness/Vertigo
__Fainting
__Glaucoma
__Heart Murmur
__Hepatitis
__HIV/AIDS
__Liver Disease
__Neurological Disorder
__Paralysis
__PREMED
__Rheumatic Fever
__Stroke/TIA's
__Tremors/Parkinson's
__Venereal Disease/HPV
__Allergy-LATEX
__Alzheimer's/Dementia
__Arthritis/Osteoporosis
__Blood Disease
__Coumadin Therapy
__Dry Mouth
__Gastrointestinal
__Head Injuries
__Heart Stent(s)
__High Blood Pressure
__Joint Replacement
__Mental Disorders
__Other
__Periodontal Disease
__Radiation/Chemo Treatment
__Sinus Problems
__Thyroid Disorder
__Trigeminal Neuralgia
__Allergy-Medication
__Anemia
__Asthma
__Bone Density Meds
__Diabetes
__Epilepsy/Seizure History
__GERD/Stomach/Colon
__Heart Disease
__Heart Valve Replacement
__High Cholesterol
__Kidney Disease
__Migraine Headaches
__Pacemaker/Defibrillator
__Pregnancy
__Respiratory Problems
__Sleep Apnea
__TMJ Issues
__Tuberculosis

Comments

INFORMED CONSENT

(Please read the following and sign below)

I hereby give Dr. Skladany and staff at Dental Design Innovations my informed consent to provide dental treatment to my child or myself.

This includes consent to undergo a comprehensive exam, including x-rays, and periodontal charting, from which a treatment plan will be formulated. From this treatment plan, Dental Design Innovations (Dr. Skladany) will provide me with an ESTIMATE of the cost of treatment. However, I understand that this is only an estimate.

I also understand that during the course of the procedure(s) unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those originally planned. I therefore authorize and request that the doctor and staff perform such procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this agreement shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.

Furthermore, I understand that no dental treatment is completely risk-free, and that Dr. Skladany will take reasonable steps to limit my complications. Possible complications in general dentistry include, but are not limited to:

- Post-op discomfort and swelling
- Injury to adjacent teeth and fillings
- Post-op infection requiring additional treatment
- Stretching of the corners of the mouth resulting in cracking/bruising
- Restricted mouth opening for several days or weeks
- Decision to leave a small piece of root in the jaw during extraction
- Injury to the nerve underlying the teeth during anesthesia (injection) or extraction resulting in numbness or tingling of the chin, lip, gums and/or tongue on the operated side; this may be persist for several weeks, months, or in remote instances, permanently
- Discoloration of the injection site or in rare cases bruising of the cheek close to injection site.
- Exposure of the nerve while preparing a tooth for a crown or filling
- The need for root canal therapy after restorative work (fillings, crowns) resulting from damage caused by the drill or deep restorations.

I understand that it is important for me to understand the treatment being rendered, pros and cons of that treatment, and any possible alternative treatments. I understand that if I do not understand the proposed treatment, it is better to ask any question I wish before treatment is started. My signature below constitutes my agreement and understanding.

PATIENT'S SIGNATURE_____ **DATE**_____

FINANCIAL AGREEMENT

I acknowledge that full payment is due at the time of treatment, unless other arrangements are made prior to treatment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a child/minor. I accept full responsibility for all charges. I understand that if I do not give at least 24-hours notice to cancel an appointment, I will be charged for that missed appointment.

PATIENT'S SIGNATURE_____ **DATE** _____

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)

Dr. Joseph M. Skladany

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 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 became effective January 27, 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 efffective 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 and 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 authoization, we cannot use or disclose your health information for any reason except those descibed 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 location) 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 professsional

judgment disclosing only health information that is directly relevant to the person's invlovment in your healthcare. We will also use our professional judment 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 use or 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 personnnel 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 offical 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.

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 acitivities, for the last 6 years. 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 disclose 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.

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 of 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 with the U.S. Department of Health and Human Services.

Contact Officer: Lisa Meilleur lisasmrn@gmail.com 10 Memorial Drive Pinehurst , NC
Telephone: 910-215-4554 **Fax:** 910-215-4554