

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 **June 1st, 2010**, and will remain in effect until we replace it.

We may change our privacy practices from time to time. If we do, we will revise this Notice so you will have an accurate summary of our practices. The revised Notice will apply to all of your health information. We may also revise this notice from time to time. If we make any material revisions to this Notice, we will provide you with a copy of the revised Notice which will specify the date on which such revised Notice becomes effective. We are required to abide by the terms of the Notice that is currently in effect. 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

A. Use and Disclosure for Treatment, Payment, and Health Care Operations

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We also use and disclose health information about you for treatment, payment, and health care operations. For example:

- Treatment: We may disclose your health information to a physician or other health care providing treatment to you.
- Payment: We may use and disclose your health information to obtain payment for services we provide to you.
- Health care Operations: We may use and disclose your health information in connection with our health care operations, including quality assessment and improvement activities, review of the competence or qualifications of health care professionals, evaluation of practitioner and provider performance, training programs, accreditation, certification, and licensing and credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care 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.

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

Disclosures To Persons Involved in Your Care: We may also 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, 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 use or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, and we will disclose only health information that is directly relevant to the person's involvement in your health care. 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, postcards, letters).

Patient-Related Communications: We may use or disclose your health information to provide patient-related communications such as intraoral photography, "no cavity club" for children, and telephoned-in prescriptions.

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

B. Use and Disclosure for the Public Need

In particular situations involving the public need, we may disclose your health information without obtaining your authorization. Those situations include the following circumstances:

Required by Law: We may use or disclose your health information when we are required by law to do so.

Public Health Activities: We may disclose your health information to authorized public health officials so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury, or disability.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections, as well as civil, administrative or criminal investigations, proceedings, or actions.

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.

Product Monitoring, Repair and Recall: We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits And Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure

Law Enforcement: We may disclose your health information to law enforcement officials for certain reasons including to comply with court orders or laws that we are required to follow, and to assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person.

To Avert a Serious and Imminent Threat to Health or Safety. 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. In such cases, we will only share your information with someone able to help prevent the threat

National Security: We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may also disclose to military authorities the health information of Armed Forces personnel under certain circumstances. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined.

Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

C. Partially De-Identified Health Information

We may use and disclose "partially de-identified" health information about you for public health and research purposes, or for business operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. If we maintain your health information in electronic format, you may request a copy of your information in electronic format and we will charge you no more than our cost of preparing the materials. If we maintain your information in paper files, you may request photocopies or copies in another format. We will use the format you request unless we cannot practically and reasonably do so. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. 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 over the last 6 years or such shorter time as you may specify. That accounting would not include disclosures made for the purposes of treatment, payment, or health care operations, unless we maintain your health record electronically, in which case, after January 1, 2011, we may need to provide you with an accounting of treatment, payment, or health care operations disclosures for no more than 3 prior years, but not including any treatment, payment, or health care operations disclosures prior to January 1, 2011. 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.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. If we agree to your request, we will abide by our agreement except in an emergency situation. However, we are not required to agree to these additional restrictions, except that we must agree to a request that we restrict disclosure of your information to a health plan for purposes of payment or health care operations if the information pertains solely to a health care item or service that you have paid for out of pocket and in full.

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 a satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment of Health Information: 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.

Notification of Breach of Unsecured Health Information: Our policy is to encrypt our electronic files containing your health information so as to protect the information from those who should not have access to it. If, however, for some reason we experience a breach of your unencrypted health information, we will notify you of the breach.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you have the right to request a paper copy of this Notice. You may make such a request by writing to the address provided at the end of this Notice.

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 INFORMATION
Chad Thompson, Corporate Compliance Officer
1200 Network Centre, Suite 2
Effingham, Illinois 62401
(217) 540-5100



FINANCIAL AGREEMENT

Thank you for choosing us to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or consider "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, and Discover. For those who qualify, we also accept Care Credit. Care Credit offers no interest financing for up to twelve months. If you choose to pay cash in full, before the treatment day we will gladly extend a 5% cash savings.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance.

• We do not file claims for medical insurance or more than one dental insurance company per patient.

PATIENTS WITHOUT INSURANCE COVERAGE

We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS

The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS

A \$25.00 charge applies when a check is returned by the bank.

We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

FINANCIAL AGREEMENT CONTINUED OVERDUE BALANCE

An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

CONSENT & AUTHORIZATION

I hereby do authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of Dr. Marvin Berlin, Dr. Jeff Lynch, Dr. Matthew Markham, and Dr. Aaron Wood DDS, PC. Without any reservations, I agree to abide by the policies outlined herein.

FORM COMPLETED BY		
Name	Signature	
IN CASE OF A CHILD: Relationship to child		
	Date	Are you the
person legally responsible for this child? Yes	No	Reviewed by staff member
Date_		



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PERMISSION TO DISCUSS DENTAL TREATMENT

In the event that you may want a **family member or friend** to discuss your dental treatment with our office, we must have permission/consent in writing from you to do so. In section "A" please list any person you give Mckinneydentist.com permission/consent to discuss your information such as xrays, account information, treatment, etc.

If you do not wish to give consent to any person, please check section "**B**" below, sign and date the bottom portion of this form. You must choose one option.

** If the patient is a minor, we will discuss dental treatment with either parent or guardian**

A. I hereby give permission/consent to dental information with the named individual	o Mckinneydentist.com to discuss any and all duals below.
Name:	Date of Birth:
Name:	Date of Birth:
B. I do not wish Mckinneydenist.com anyone other than me.	to discuss any of my dental treatment with
Health Insurance Portabili	ity & Accountability Act-HIPAA
I,	, understand that under the Health t of 1996 ("HIPAA"), I have certain rights to ormation. I understand that this information
	nent and follow-up among the multiple nvolved in that treatment directly and
Obtain payment from third-party party	payers. ions such as quality assessments and physician
complete description of the uses and discl that I may request in writing that you rest disclosed to carry out treatment, payment	r Notice of Privacy Practices containing a more osures of my health information. I understand rict how my private information is used or or health care operations. I also understand sted restrictions, but if you do agree then you
Signature:	Date:

PATIENT REGISTRATION

Size M F Birndate Size M F Birndate Size Zip	Patient Number	ABC				Today's Date			
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Are you a full time student? □ Yes □ No. If patient is minor we need: Direct #	Your		Work						
Person responsible to a special page Dirver's Relationship		─────────────────────────────────────	Mother's		Father's				
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Insured's name Insured's employer Insurance Co Insurance Co Address Phone # DOB SS# Group # Local # DOB FINANCIAL POLICY Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bills considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside linancing is available upon request and approvals. Please check if you would like more information about financing options. Please check if you would like more information about financing options. Please hote; Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%. Do You Have Insurance? As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company, Your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company to your insurance company. Our office is not a party to that contract. Our practice is committed to providing the best treatment for our patients and we charge what is	this visit How did you hear								
Insured's employer Insurance Co Insurance Co Address Phone # DOB SS# Group # Local # FINANCIAL POLICY Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval. Please After: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%. Do You Have Insurance? As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. All charges you incur are your responsibility regardless of your insurance company and your plan benefits ultimately determine the amount paid. We will, or you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company to make payment directly to our office. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company, by cash, check, MasterCard, Visa, or Discover at th	DENTAL INSURANC	E INFORMATION (Primary Carri	er)	If you have double	digit insurance coverage, c	omplete this for the 2nd coverage			
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FINANCIAL POLICY Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval. Please check if you would like more information about financing options. Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%. Do You Have Insurance? As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. All charges you incur are your responsibility regardless of your insurance coreage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment engardless of any insurance company's arbitrary determination of usual and customary rates. We ask that you sign this form and/or any other necessary documents that may be required by your insu	Phone #	DOB		Phone #		DOB			
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the full amount at that time. • We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into dispute with your insurance company over any claim. We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy. Consent: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENE-	attain optimum oral health. that payment of your bill is Visa and Discover. Outsid Please check if you woul Please Note: Returned ch you will be responsible for Do You Have Insurance? • As a courtesy to you we guarantee that your insucourse, do all we can to end to have a discourse, and the contract. • Our patient, not with party to that contract. • Our practice is committee regardless of any insurative wask that you sign this to make payment directle. • We ask that you pay the Discover at the time we	r office as your dental healthcare provided. The following is a statement of our final considered part of your treatment. Payre e financing is available upon request and dike more information about financing ecks will be subject to additional fees. In any collection and/or legal charges up to exist will help you process all your insurance urance will pay exactly as estimated. You make sure your estimate is as accurate the your responsibility regardless of your in your insurance company. Your insurance ad to providing the best treatment for our since company's arbitrary determination of its form and/or any other necessary document of the provide the service to you.	er. We are commit notal policy, which nent is due at the dapproval. In poptions. It the case it become a 35%. It claims. Please under insurance comparase possible. In patients and we compare the policy is a contract of usual and custom ments that may be the estimated amound the source of the source of the source of usual and custom ments that may be the estimated amound the source of th	ted to providing you we require that yo time service is proved as necessary for or derstand that we wany and your plant to the work of the	ou with the highest qualit u read, agree to, and sig wided. Our office accept our office to enlist a colle will provide an insurance benefits ultimately deterr size that as your dental of your employer, and your all and customary for our insurance company. This	in prior to any treatment. Please note is cash, personal checks, MasterCard, ction service and/or legal assistance, estimate to you, however it is not a mine the amount paid. We will, of care provider, our relationship is with insurance company. Our office is not a area. You are responsible for payment is form instructs your insurance company, by cash, check, MasterCard, Visa, or			
ELLO LIDELLA ELLA MAT LIENTAL LIEULE. L'HODESSADO DA L'ESDODSIDIIIV DE DAVIDADI DE L'ADRIA SON/IDAG DENOMINA IN TRIC DELLA TRIVIALITÀ DE MARCANA DE LA MARCANA DELLA DE	that you contact your ins the full amount at that tii • We will cooperate fully v dispute with your insura. We thank you for the oppo Consent: I HAVE READ, UNDERSTA	surance company to make sure payment me. vith the regulations and requests of your nce company over any claim. rtunity to serve your dental health care n AND AND AGREE TO THE ABOVE TER	is expected. If par insurance compar eeds and welcome MS AND CONDIT	ment is not receively that may assist it any questions you	ed or your claim is denied or your claim is denied in the claim being paid. On the concerning It may have concerning ZE MY INSURANCE CO	ed, you will be responsible for paying Our office will not, however, enter into a your care or our financial policy. DMPANY TO PAY MY DENTAL BENE-			

Patient Signature (Parent if child)

and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

DENTAL HISTORY

Please check any of the follow that apply to you.	ving problems	es No		If you could whiten your tee anyone could afford, would	you do it?	SI.	Yes	No	
-Sensitivity (hot; cold, swee Where? UR LR U	*			Do you smoke or use chewi How much?	-				
-Headaches, earaches, neck paragraphs -Jaw joint pain -Teeth or fillings breaking -Grinding or clenching teeth -Bleeding, swollen or irritat -Loose, tipped or shifting tees -Bad breath Do you have or have you had -Dentures	n ted gums teth any of the following?			If I could change my smile, -Make it whiter -Make it straighter -Close spaces -Replace black metal filli colored restorations -Repair chipped teeth -Replace missing teeth -Replace old crowns that	I would:	oth			
-Partial dentures -Braces -Periodontal (gum) treatmen				-Have a smile makeover ON A SCALE OF 1-10, W	/ITH 10 BE	EING THE HI			ING:
Please share the following dat - Your last cleaning - Your last oral car - Your last comple	g / ncer screening /			How important is your denta 1 2 3 4 Where would you rate your 1 2 3 4 Where do you want your de	5 current den 5	6 7 atal health? 6 7	8		10 10
Name of Previous Dentist _				1 2 3 4	5	6 7	8	9	10
City	State			Why did you leave your pre	vious denti	st?			
Phone Number									
What is the most important th What is the most important th				alth?					
Diagon shook any of the following	M	EDI	CAL	HISTORY					
Please check any of the fol yes	NO	Υ	ES NO		YES NO			YE	ES NO
AIDS	 □ Dizziness □ Drug Addiction □ Emphysema □ Epilepsy □ Excessive Bleedir □ Fainting □ Glaucoma □ Heart Conditions □ Heart Lesions (Co □ Heart Murmur □ Heart Surgery □ Hepatitis A □ Hepatitis B □ Hepatitis C □ High Blood Press 	ng [ngenital) [cure [cur		HIV Positive HPV (Human Papilloma Virus) Jaundice Jaw Joint Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervousness/Depression Pacemaker Pregnant Currently Radiation (head/neck) Respiratory Problems Rheumatic Fever Rheumatism medications?			ems a oblem ease s	ns CCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCC	
Aspirin	Percodan	Codei	ycline 🗆	□ Penicillin □	NO □ □ □	Other			
Have you ever taken any the	ne following medications?		Are you	under a physician's care?	What for?				
Actonel	Zometa		What me	at medications are you currently taking? Thilly Physician Phone Number					
Aredia Fosamax Reclast	Boniva		Family F						
Consent: The undersigned herby author thorough diagnosis of the patie ed. I also understand the use of	ent's dental needs. I also autho	orize Doct	tor to perfo	orm any and all forms of treatr	ment, medic	ation and there	apy th	at may b	
Patient Signature (Parent if child))		Date	Dentist	Signature				