Ralph W. Price, D.D.S.
Practice Limited to Periodontics
4400 N 32nd Street, Suite 100, Phoenix, AZ 85018
602-956-1114

PATIENT DEMOGRAPHIC INFORMATION

Mr. Mrs. Miss Ms. Dr. _____
Last First Middle Initial

I wish to be called at: home /work / cell / email / texted Name of Spouse/Partner_____

If you wish to be texted what wireless carrier to you have? _____

Cell Phone (__)_____ Email address _____

Home Phone (____) _____Work Phone (___) _____Ext.#_____

Address _____Apt. No. _____

City, State, Zip _____

Birthdate _____ Social Security # _____-_____-_____

Referred by _____Your General Dentist _____
(If Different from Referral)

Pharmacy Name & Location: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of insured_____

Relationship to Patient_____

Insured's Birthdate _____

Soc. Sec. # or ID # _____-_____-_____

Employer_____

Insurance Co. _____

Group # _____

Group Name _____

Secondary Insurance

Name of Insured_____

Relationship of Patient_____

Insured's Birthdate _____

Soc. Sec. # or ID #_____-_____-_____

Employer _____

Insurance Co. _____

Group # _____

Group Name _____

_____I am not covered by any Dental Insurance at this time

I hereby authorize Provider, or his staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Provider_1 of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Dental Association, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Provider_2.

Privacy of Information Policy: I have been informed that this practice will make reasonable effort to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996 and have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

Cancellation Policy: There will be a substantial charge if a surgical treatment appointment is canceled with less than 5 working days' notice. All other appointments require 1 full working days' notice for any change. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.

_____ _____
Signature of Patient or Patient's Legal Guardian Date of Signature

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Practice Limited to Periodontics-Implants

Medical History

Patient's Name:_____

Welcome. Please take a few minutes to complete the following questions to the best of your ability. These questions will help us to deliver the best possible care.

1. Are you in good health? yes no
   a. Has there been any change in your health in the past year? yes no

2. My last physical was on (date).
   _____

3. Are you under the care of a physician? yes no
   a. If so, what condition is being treated?
   _____

4. The name, address and phone number of my physician is: _____
   _____
   _____

5. Have you had any serious illness, operation or been hospitalized in the past 5 years? yes no
   If yes, what was the illness? _____
   _____
   _____

6. Are you taking any of the following:
   a. Antibiotics or sulfa drugs yes no
   b. Anticoagulants (blood thinners) yes no
   c. Medicine for high blood pressure yes no
   d. Cortisone (steroids) yes no
   e. Tranquilizers yes no
   f. Aspirin yes no
   g. Insulin, tolbutamide (Orinase) or similar drug yes no
   h. Digitalis/drug for heart trouble yes no
   i. Nitroglycerin yes no
   j. Antihistamine yes no
   k. Thyroid medication yes no
   l. Hormone therapy yes no
   m. Vitamins yes no
   n. List medications you currently take or provide a list if available: _____
   _____
   _____

7. Are you allergic or have you reacted adversely to:
   a. Local anesthetics yes no
   b. Penicillin or other antibiotics yes no
   c. Sulfa drugs yes no
   d. Barbiturates, sedatives, sleeping pills yes no
   e. Aspirin yes no
   f. Iodine yes no
   g. Codeine or other narcotic yes no
   h. Any other drug or medications: yes no
   (please list) _____
   _____

8. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease yes no
   b. Congenital heart lesions yes no
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, artiosclerosis, stroke)
   yes no
   1. Heart murmur yes no
   2. Mitral Valve Prolapse yes no
   d. Allergy yes no
   e. Asthma yes no
   f. Hives yes no
   g. Fainting spells or seizures yes no
   h. Diabetes yes no
   i. Diabetes in your family yes no
   j. Hepatitis, jaundice, liver disease yes no
   k. Arthritis yes no
   l. Inflammatory rheumatism yes no
   m. Stomach ulcers yes no
   n. Fainting or convulsions yes no
   o. Artificial joint/implant yes no
   p. Nervous problems yes no
   q. Alcoholism or drug addiction yes no
   r. HIV positive blood yes no
   s. Kidney trouble yes no
   t. T.B. or other respiratory problems yes no
   u. Persistent cough or cough up blood yes no
   v. Low blood pressure yes no
   w. Venereal disease yes no
   x. Please list any other diseases not specifically mentioned: _____
   _____
   _____

please continue on page 2

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Medical History (page 2)

9. Do you have any disease, condition or problem not listed above that you think I should know about? yes no
   If yes, please describe_____
   _____

10. Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation? yes no

11. Have you had abnormal bleeding associated with previous extractions, surgery or any other trauma? yes no
    a. Do you bruise easily? yes no
    b. Have you ever required a blood transfusion? yes no
    If so. please explain the circumstances:
    _____

12. Do you have any blood disorder such as anemia? yes no

13. Have you had any serious trouble associated with any previous dental treatment? yes no
    If so, please explain:
    _____

14. Have you had any surgery or x-ray treatment for a tumor, growth or other condition? yes no

15. Do any or your following family members have a history of losing a number of their teeth?
    Father yes no
    Mother yes no
    Brother(s) yes no
    Sister(s) yes no

16. Are you or have you in the past taken medications called Bisphosphonates for Osteoporosis, cancer treatment or Paget's Disease (Actonel, Bonefos, Boniva, Didronel, Fosamax, Ostac, Skelid (orally) or Aredia, Zometa (Intravenously)? yes no

Women Only:

17. Are you pregnant? yes no

18. Do you have any problems associated with your menstrual period? yes no

19. Have you reached menopause? yes no

Dental History and Information

1. Why do you seek dental care at this time?
   _____

2. How important is keeping your teeth?
   _____

3. Do you see a general dentist regularly? yes no
   Your dentist's name: _____
   Date of your last dental cleaning:
   _____

4. Have you had previous periodontal treatment? yes no
   If so, when? _____
   Have you had previous root planing (deep scaling)? yes no

5. Do you have or recently had any of the following:
   a. bleeding gums yes no
   b. swelling of your gums yes no
   c. grinding or clenching of your teeth yes no
   d. shifting of teeth yes no
   e. trouble with your "jaw joint" yes no
   f. pain in the ear region yes no
   g. dental or oral pain yes no
   h. bad breath or taste yes no
   i. tired jaw or facial muscles yes no
   j. difficulty chewing yes no

6. Do you follow a special diet? yes no

7. How many meals do you eat daily? _____

8. Do you smoke? yes no
   If yes, what and how much? _____
   _____

9. Which of the following do you use on a daily basis to maintain your teeth for life?
   a. brush yes no
   b. floss yes no
   c. water spray device yes no
   d. toothpick/gum massager yes no
   e. any other devices including an electric toothbrush yes no
   f. any mouthwash yes no

10. Are you pleased with the appearance of your teeth? yes no

Thank you for bearing with us and completing this form.

Date: _____

Your Signature: _____

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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: Ralph W. Price, D.D.S.

Telephone: 602-956-1114 Fax: 602-954-4783

E-mail: office@priceperio.com

Address: 4400 N. 32nd. St. Suite 100, Phoenix, AZ 85018

Ralph W. Price, D.D.S., PC, Practice Limited to Periodontics

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ralph W. Price, DDS

Telephone: (602) 956-1114 Fax: (602) 954-4783

E-mail: office@priceperio.com

Address: 4400 N. 32nd St., Suite 100, Phoenix , AZ 85018

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____