Germany Dental

Patient Name_____ Preferred Name_____

Address_____ City/State_____ Zip_____

SS#_____ Date of Birth_____ Gender_____ Single or Married

Phone #s: Home_____ Work_____ Cell_____

Employer_____ Email_____

Emergency Contact Name_____ Phone_____

Whom may we thank for referring you to us? _____

Last dentist visit_____ Reason for today's visit_____

Please circle or list any allergies:

Aspirin
Codeine
Latex
Penicillin
Sulfa
Other: _____

Please circle if you have, have had or have any of the following:

Allergies/Hay Fever
Artificial Joints*
Anemia
Asthma
Blood Disease
Cancer
Diabetes
Epilepsy or Seizures
Excessive Bleeding
Fainting
Head Injuries
Heart Disorder*
Heart Murmur*
Hepatitis
High Blood Pressure
Heart Pacemaker*
Heart Surgery*
Kidney Disease
Liver Disease
Mental Disorder
Mitral Valve Prolapse*
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Sinus Problems
Stroke
Surgical Shunt*
Tuberculosis
Ulcers
Venereal Disease
HIV/AIDS
Other: _____
_____

* This condition may require antibiotic premedication for certain dental procedures.

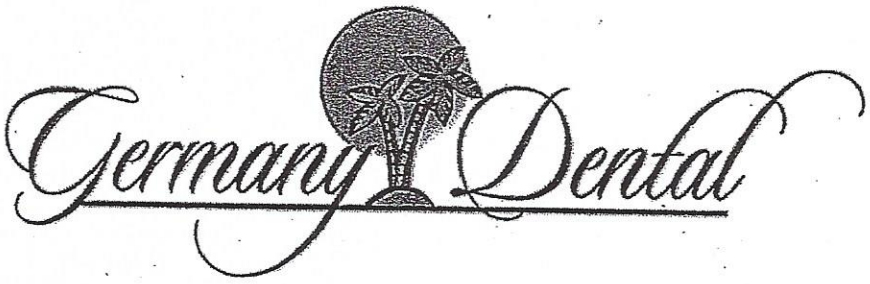
Have you ever had any complications following dental treatment? _____
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care in the past 2 years? _____
If yes, please explain: _____

Are you now under the care of a physician? _____
If yes, please explain: _____ Physician Name and Phone #_____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I will inform the dentist and the staff at the next appointment without fail.

X _____ Date: _____



Financial Agreement

Payment is expected in full at the time services are rendered. We offer several methods of payments including: Cash, Check, Credit Cards (We Accept Most Major Credit Cards), and Financing (Care Credit). If your account becomes past due and collection procedures are rendered, you will be responsible for ANY and ALL cost.

X _____ Date:_____

X _____ Date:_____

(Parent/Guardian if patient is under 18)

For Patients with Dental Insurance

If you have dental insurance, we will gladly process your claim with your primary dental insurance provider. Insurance limitations and regulations vary with all insurance plans. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance. However, we will do our best to work with your insurance and help in every way we can. <u>You will be responsible for the entire portion of your bill, if insurance has not paid within 45 days.</u>

Insurance policy holder if different from patient_____

Relationship to patient [ ] Spouse [ ] Child [ ] Other _____

Policy Holder Social Security #_____Date of Birth_____

Insurance Company_____Phone #_____

Insurance Group Name_____Group #_____

(This is more than likely the policy holder's employer).

PRESCRIPTION/DRUG POLICY

1. Prescriptions will not be refilled after normal business hours, on holidays, or weekends when Dr. Germany does not have your records. This is for your safety and the safety of others. An early refill on your pain medicine will NOT be granted if you take more than the prescribed amount.

2. Prescription refills should be called into your pharmacy or to our office during regular office hours. It may take up to 24 hours to refill a prescription.

3. Prescriptions will not be refilled if you have cancelled your last appointment, did not show for your last appointment, or if you do not follow through with recommended treatment. Prescriptions will not be refilled if you have been discharged from the practice, or if you were to return only as needed. WE DO NOT PRACTICE PAIN MANAGEMENT.

4. Prescriptions that have been lost or discarded will not be refilled.

5. Prescriptions that have been stolen will not be refilled.

6. During the time of our care in this office, unless we have referred you to a pain management specialist, this office will be the ONLY SOURCE OF YOUR PAIN MEDICAITION. You may still receive other medication (for example: for infection, swelling, etc.) from your family doctor, but only ONE doctor should ever prescribe pain medication at a time.

7. It is our legal duty to report to the authorities the name of patients who we believe may be taking, selling, or distributing narcotics or other medications illegally.

8. We reserve the right to terminate the doctor-patient relationship in the event of any breech in this policy by the patient.

I HAVE READ ABOVE AND UNDERSTAND THE PRESCRIPTION-DRUG POLICY.

X _____ Date: _____

HIPAA Release Form Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information used or disclosed to us in any form be kept confidential. The federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and /or leaving messages at home and /or at work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent we have already taken actions relying on your authorization.

For more information about our Privacy Practices, please contact our office.

I have reviewed Germany Dental's Notice of Privacy Practices and understand that more information is available upon request. I also certify that I have read and understand the above information to the best of my knowledge. I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I also give Germany Dental permission to discuss or release my dental records to the names listed below. If no other individuals are to receive information, please place NONE in the spaces below.

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

NAME_____ RELATIONSHIP_____

Signature of Patient/Guardian_____ Date_____

NO EXPIRATION UNTIL REQUIRED BY LAW

Patient Arbitration Agreement

I, the patient, engage Jonathan D. Germany, D.M.D, P.A. ("Germany Dental Clinic"), Dr. Jonathan Germany DMD, or employee thereof, to perform services in conjunction with patient's medical care. For and in partial consideration of the edition of any and all present and future medical or dental care and services, patient agrees that in the event of any dispute, claim or controversy arising out of or relationg to the performance of medical and dental services including but not limited, to patient fees, informed consent, negligence or medical or dental malpractice, between Patient (whether a minor or an adult) or the heirs-at-law or personal representation of patient, as the case may, and the Germany Dental Clinic, Dr. Jonathan Germany D.M.D., or employee personal representation of patient, as the case may, and the Germany Dental Clinic, Dr. Jonathan Germany DMD, or employee thereof, where the claim or the amount in controversy exceeds $5,000, such dispute or controversy shall be submitted to JAMS, or an arbitration firm for final and binding arbitrations. All claims for liquidated damages shall be deemed claims for an in excess of $5,000.

Either party may initiate arbitration of any matter subject to arbitration by filing a written demand for arbitration at any time. Patient shall be entitled to an in-person hearing in his or her county in accordance with the Federal Arbitration Act. The arbitration shall be administered by Jam pursuant to its Comprehensive A\arbitration Rules and Procedures and Minimum Standards of Procedural Fairness, and all parties agree to be bound by the arbitrator's decision. Any decision by the arbitrators shall be accompanied by a reasoned opinion. Judgment may be entered on the arbitrator's award, if any, by a court having jurisdiction of the matter.

All parties agree that their relationship affects interstate commerce and this agreement shall be governed by the Federal Arbitration Act and, if not, by Mississippi law. The party requesting arbitration shall bear all costs of the arbitration, except the patient is not required to pay any more than $125.00, with Germany Dental Clinic bearing the other arbitration costs.

If you are not willing to submit to binding arbitration, the Germany Dental Clinic may perform series or refer to you another health care provider capable of rendering the medical care or dental care or service which you require (although Germany Dental Clinic assumes no responsibility for the quality of care or services rendered by any other health care provider). Please inform Germany Dental Clinic immediately if you do not agree to binding arbitration and desire such referral.

This agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claims or disputes related to medical services rendered after execution of this agreement and prior to the date of such written notice of recession shall bye subject to the terms of this agreement. Written notice of such recession may be given by a guardian or conservator of Patient, if Patient is a minor or incapacitated. If any person of the agreement is found unenforceable, that potion shall be stricken and the remainder of this agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, patient agrees the suit will be heard in the county where services are rendered.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE A AGREEING TO HAVE ANY CLAIM NEGLICGENCE OR MEDICAL MALPRACTICE BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIOANL RIGHT TO JURY OR COURT TRAIL.

Witness our signature this is the _____ day of _____, 20_____.

Jonathan D Germany, D.M.D., PA D.B.A. Germany Dental Clinic

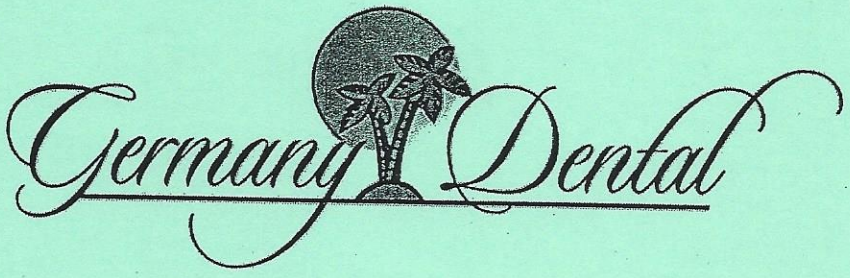
X_____(Patient)

X_____(Parent or guardian if patient is a minor)

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he or she has full legal authority to execute this arbitration agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless Germany Dental Clinic from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

_____(Authorized Representative)

A photo static or electronic copy of this authorization shall be considered as effective and as valid as the original.



List of Medications

Please list all medications that you are currently taking including prescriptions, over the counter medications, and the medication you take occasionally or as needed.

If you do not know the names of the prescriptions, please include your pharmacy name and telephone number.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

X_____ Date_____

If I have any changes in my medications, I will inform the dentist and the staff.