DAVID A. WRIGHT, D.D.S., P.C.
Family and Cosmetic Dentistry

Your Initial Dental Examination

The most important appointment you will have at our office is your *Initial Oral Examination* . This examination enables us to examine your mouth and teeth, take the necessary radiographs (X-rays), and then have ample time to discuss your dental needs.

During this examination we will be examining your temporomandibular joint (TMJ), your face, neck, hard and soft palate, throat, cheeks and tongue. This is part of our screen for oral and facial cancers, which are most successfully treated if detected early. We will also do a thorough screening for periodontal diseases, which are the leading cause of adult tooth loss. Also, we will examine your teeth for decay, broken fillings, cracks, and mobility.

A series of important radiographs is taken if a current one does not exist. These films allow us to screen for decay, periodontal problems, certain cysts, abscesses and tumors. Many dental problems would go undetected without the use of these films until the problems reach advanced stages. Please let us know if you have any current radiographs at another dental office so that we can send for them *before* your appointment.

Children

During their first visit, children will receive a complete examination, have their teeth cleaned, fluoride applied, and any necessary radiographs taken. A major emphasis will be placed on teaching them prevention, including proper home care and diet.

Adults

The adult exam is so thorough that we schedule one and a half hours for it. We allow ample time at the end to discuss treatment options, although at times we reserve this for a separate appointment. For this reason, we do not "clean" teeth at the introductory appointment. We assure you, however, that this important service will take place quickly. Those patients with Periodontitis will receive special care.

We also make every attempt to make your dental appointments as comfortable and as easy as possible. This initial appointment is also a good time to discuss any special needs that you have such as Nitrous Gas.

Thank you for taking the time to read this important letter. We feel strongly that we can save people time, money, trouble and their teeth by being thorough and preventive in our approach. If any problems do exist, it will allow for earlier detection, and easier and less costly treatment. An undiagnosed dental condition will not go away, it will just worsen.

We have allotted a large amount of time for this examination, so we ask that you respect our time and keep your scheduled appointment. Thank you, we look forward to meeting you!

Sincerely,

DAVID A. WRIGHT, D.D.S., P.C.

4152 SASHABAW ROAD WATERFORD, MICHIGAN 48329 TELEPHONE (248) 673-0505

PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM

DATE_____

PATIENT'S NAME _____ DATE OF BIRTH_____

SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS_____ PHONE_____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____ PHONE_____

ADDRESS_____

EMPLOYED BY_____ BUSINESS PHONE_____

BUSINESS ADDRESS_____ PATIENT'S SS#_____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY_____

PATIENT'S NAME

DENTAL HISTORY

CHIEF ORAL COMPLAINT_____

DATE OF LAST DENTAL EXAM_____ ANY PREVIOUS MAJOR DENTAL TREATMENT: ☐ YES ☐ NO WHEN_____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long _____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting, cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Alcohol
- ☐ Medical marijuana
- ☐ Recreational drugs

MEDICAL HISTORY

PHYSICIAN'S NAME_____ DATE OF LAST EXAM_____ AGE____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Latex sensitivity
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotionalproblems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy If so, what month_____
- ☐ Venereal disease
- ☐ Other_____

Describe any current medical treatment including drugs taken, even though not listed above_____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

SIGNATURE_____ DATE_____

(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)

David A. Wright, DDS, PC Payment Policies

For your convenience we accept many methods of payment. These include cash, checks and credit/debit cards. **Our goal is to keep our treatment fees as low as possible for you**; therefore, we have very simple and timely payment arrangements. **This way the dollars you spend will go towards quality dentistry instead of financing costs and paper-chasing costs.**

Patients without insurance or who have used up all insurance benefits: Payment is due in full at the time of service. Payment plans are not provided in these cases because the Visa/MasterCard/Discover offers a simple way for patients to create their own payment plans.

Patients with insurance: For new patients, our office staff will call to verify your dental benefits and get the approximate breakdown of coverage before your first appointment. In the event we are unable to verify your insurance prior to your first visit you can pay our office "out of pocket" and we will have your insurance company reimburse you directly for that claim. ***All patients are responsible for estimated deductibles and copayments on the date of service, based on available information.*** After the insurance payment has been received by our office, the patient is responsible for any outstanding balance resulting from "usual and customary" allowances or because of insurance denial of the claim. If the insurance company overpays (pays more than we expected), the patient's account will be credited or a check will be issued to the patient. Additional payment is expected in a timely fashion (within 30 days of notification).

Patients with dual insurance: The insurance form will first be sent to the primary carrier. After payment is received it is then sent on to the secondary carrier. After the secondary insurance payment has been received, any amount due will be paid by the patient in a timely fashion.

Children/Minors: The parent who brings the child to the appointment is responsible for the payment on the date of service. If the child (teenager) is unaccompanied, payment must still be made.

Insurance: How accurate are our estimates? We will take considerable time providing estimates of what your insurance will cover. The vast majority of the time these estimates are remarkably accurate. Unfortunately insurance companies are not always honest with us and will seemingly randomly change coverage amounts or unexpectedly deny coverage. We therefore are not able to guarantee our estimates and you will be responsible for anything your insurance will not cover. In a perfect world we would love to be able to always give you exact numbers, but the insurance companies make this impossible. We understand your frustration with this imperfect system, and we pledge to work together with you to make this arrangement work as well as possible. Thank you!!!

David A. Wright, DDS, PC

Reserved Time System

We have found that patients appreciate personalized, "on time" dental care. We are able to provide this because we do not overbook, and because our patients show up for the appointments for which they have committed. This also helps us to control our costs, and therefore our fees.

Therefore, over the years we have forged the following arrangement with our patients:

1. Our patients agree to keep the appointments that they make, within 15 minutes.
2. We agree that we should be on time for appointments, within 15 minutes.
3. We agree to understand if something happens that simply will not allow a patient to keep their appointment; we ask the same of our patients.
4. Our patients understand that we will charge $50.00 per appointment hour for repeated offenders of this agreement. We ask for ***48 hours*** notice to cancel or reschedule an appointment. We reserve the right to terminate our relationship if this pattern of behavior continues.
5. We also agree to pay $50.00 if we repeatedly break our appointments.
6. We agree to work on this with all of our patients, so that we can keep our fees down for everybody. This also avoids the need to "overbook" (which is how many medical and dental offices overcome broken appointments). This in turn allows us to provide better care for you, our patient.

We hope that this sounds fair to you and we ask that you accept this agreement by signing below. We want this to be your office every bit as much as it is ours. ***It simply is our goal to give you a different and better experience for your dental care than you have received before coming here. This agreement helps to make that possible.*** THANK YOU!

I have read the above and I understand the Reserved Time System used at *David A. Wright, DDS, PC:*

_____ _____

Patient's Signature Date

_____

Staff Signature

DAVID A. WRIGHT, D.D.S., P.C.

{NAME OF PRACTICE}

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)

_____

_____

_____

DAVID A. WRIGHT, D.D.S., P.C.

{NAME OF PRACTICE}

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 4 / 1 / 03, 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._____ for each page, $_____ 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: Dr David Wright

Telephone: 248-673-0505 Fax: 248-673-~~0505~~ 8803

E-mail: VI

Address: _____

David A. Wright, D.D.S., F.A.C.D., M.B.A.
4152 Sashabaw Road
Waterford, Michigan 48329