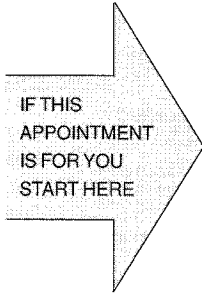


PATIENT REGISTRATION

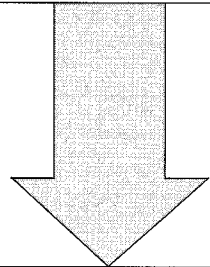
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



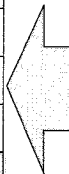
| | | | | |
|-------------------------|--------|----------|---------|----------|
| DATE | | | | 1 |
| LAST NAME | | FIRST | M.I. | |
| PREFERS TO BE CALLED BY | | | | |
| ADDRESS | | | | |
| CITY | | STATE | ZIP | |
| HOME PHONE NO. | | FAX | | |
| CELL | | EMAIL | | |
| BIRTHDATE | AGE | MALE | FEMALE | |
| MARRIED | SINGLE | DIVORCED | WIDOWED | |
| SOCIAL SECURITY NO. | | | | |
| DATE | | | | |
| LAST NAME | | FIRST | M.I. | |
| ADDRESS | | | | |
| CITY | | STATE | ZIP | |
| HOME PHONE NO. | | | | |
| BIRTHDATE | AGE | MALE | FEMALE | |
| SCHOOL | | GRADE | | |
| SOCIAL SECURITY NO. | | | | |

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

| | | |
|-------------------------------|-------------------------|----------|
| DENTAL INSURANCE | | 2 |
| PRIMARY CARRIER | | |
| INSURANCE COMPANY | | |
| GROUP NO. | | |
| EMPLOYER NAME | | |
| INSURED'S NAME | | |
| DATE OF BIRTH | RELATIONSHIP TO PATIENT | |
| INSURED'S I.D. NO. | | |
| INSURED'S SOCIAL SECURITY NO. | | |
| SECONDARY CARRIER | | |
| INSURANCE COMPANY | | |
| GROUP NO. | | |
| EMPLOYER NAME | | |
| INSURED'S NAME | | |
| DATE OF BIRTH | RELATIONSHIP TO PATIENT | |
| INSURED'S I.D. NO. | | |
| INSURED'S SOCIAL SECURITY NO. | | |



| | | |
|--|---------------------|----------|
| ACCOUNT INFORMATION | | 4 |
| PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT | | |
| NAME | | |
| RELATIONSHIP TO PATIENT | SOCIAL SECURITY NO. | |
| ADDRESS | | |
| CITY | STATE | ZIP |
| PHONE NO. | | |
| YOU | | |
| NAME | | |
| OCCUPATION | | |
| EMPLOYER'S NAME | | |
| ADDRESS | CITY | |
| PHONE NO. | FAX NO. | |
| YOUR SPOUSE | | |
| NAME | | |
| OCCUPATION | | |
| EMPLOYER'S NAME | | |
| ADDRESS | CITY | |
| PHONE NO. | FAX NO. | |



| | | |
|---|---------------|----------|
| GETTING TO KNOW YOU | | 3 |
| IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE? | | |
| NAME: | RELATIONSHIP: | |
| YOU WERE REFERRED TO US BY | | |
| YOUR FORMER ADDRESS | | |
| CITY | STATE | ZIP |
| PERSON TO CONTACT FOR EMERGENCY | | |
| PHONE NUMBER | | |
| ADDRESS | | |
| CITY | STATE | ZIP |
| CLOSEST RELATIVE NOT LIVING WITH YOU | | |
| PHONE NUMBER | | |
| ADDRESS | | |
| CITY | STATE | ZIP |

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

Patient Name _____
 Patient Account No. _____

DENTAL HISTORY

Medical Alert _____

*Welcome! So that we may provide you with the best possible care
 please complete both sides of this medical/dental history form.
 All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? Yes No
 Sweets? Yes No
 Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No
 Do you frequently get cold sores, blisters or
 any other oral lesions? Yes No

Do your gums bleed or hurt?

Have your parents experienced gum disease
 or tooth loss? Yes No
 Have you noticed any loose teeth or change
 in your bite? Yes No

Does food tend to become caught in between
 your teeth? Yes No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? Yes No
 Bite your lips or cheeks regularly? Yes No
 Hold foreign objects with your teeth?
 (pencils, pipe, pins, nails, fingernails) Yes No
 Mouth breathe while awake or asleep? Yes No
 Have tired jaws, especially in the morning? Yes No
 Snore or have any other sleeping disorders? Yes No
 Smoke/chew tobacco or use other tobacco products? Yes No

Have you ever had:

Orthodontic treatment? Yes No
 Oral Surgery? Yes No
 Periodontal treatment? Yes No
 Your teeth ground or the bite adjusted? Yes No
 A bite plate or mouth guard? Yes No
 A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw? Yes No
 Pain? (joint, ear, side of face) Yes No
 Difficulty in opening or closing the mouth? Yes No
 Difficulty in chewing on either side of the mouth? Yes No
 Headaches, neckaches or shoulder aches? Yes No
 Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

(Please complete other side)

MEDICAL HISTORY

Patient Name _____

Patient Account No. _____

Medical Alert _____

1. Have you been under the care of a medical doctor during the past two years?..... Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years?..... Yes No
3. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines?..... Yes No
 If yes, please list name and dosage _____
4. Have you ever taken any prescription drugs for weight loss, including Fen-Phen (fenfluramine-phentermine); Pondimin (fenfluramine); and Redux (dexfenfluramine)?..... Yes No
 If yes to the above, did you have a medical exam for heart issues?..... Yes No
5. Are you aware of having an allergic (**or adverse**) reaction to any medication or substance?..... Yes No
 If yes, please list: _____
6. Have you been a patient in the hospital during the past five years?..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

| | | | | | | | | |
|---|-----|----|-------------------------|-----|----|-------------------------------------|-----|----|
| Heart (Surgery, Disease, Attack).... | Yes | No | Ulcers..... | Yes | No | Hepatitis A B C (circle) ... | Yes | No |
| Chest Pain..... | Yes | No | Diabetes..... | Yes | No | Venereal Disease..... | Yes | No |
| Congenital Heart Disease..... | Yes | No | Thyroid Problems..... | Yes | No | A.I.D.S..... | Yes | No |
| Heart Murmur..... | Yes | No | Glaucoma..... | Yes | No | H.I.V. Positive..... | Yes | No |
| High Blood Pressure..... | Yes | No | Contact lenses..... | Yes | No | Cold Sores/Fever Blisters..... | Yes | No |
| Mitral Valve Prolapse..... | Yes | No | Emphysema..... | Yes | No | Blood Transfusion..... | Yes | No |
| Artificial Heart Valve..... | Yes | No | Chronic Cough..... | Yes | No | Hemophilia..... | Yes | No |
| Heart Pacemaker..... | Yes | No | Tuberculosis..... | Yes | No | Sickle Cell Disease..... | Yes | No |
| Rheumatic Fever..... | Yes | No | Asthma..... | Yes | No | Bruise Easily..... | Yes | No |
| Arthritis/Rheumatism..... | Yes | No | Hay Fever..... | Yes | No | Liver Disease..... | Yes | No |
| Cortisone Medicine..... | Yes | No | Latex Sensitivity..... | Yes | No | Yellow Jaundice..... | Yes | No |
| Swollen Ankles..... | Yes | No | Allergies or Hives..... | Yes | No | Neurological Disorders..... | Yes | No |
| Stroke..... | Yes | No | Sinus Trouble..... | Yes | No | Epilepsy or Seizures..... | Yes | No |
| Diet (Special/Restricted)..... | Yes | No | Radiation Therapy..... | Yes | No | Fainting or Dizzy Spells..... | Yes | No |
| Artificial Joints (hip, knee, etc.).... | Yes | No | Chemotherapy..... | Yes | No | Nervous/Anxious..... | Yes | No |
| Kidney Trouble..... | Yes | No | Tumors..... | Yes | No | Psychiatric/Psychological Care..... | Yes | No |
8. Do you use more than two pillows to sleep?..... Yes No
9. Have you lost or gained more than 10 pounds in the past year?..... Yes No
10. Do you have or have you had any disease, condition, or problem not listed?..... Yes No
 If yes, please list: _____
11. **Women:** Are you pregnant or think you may be pregnant? Yes, ___ Months No **Nursing?** Yes No
12. **Women:** Do you use birth control medications?..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____



Fredric C. Gaeta DDS
75-5706 Hanama Place Suite 105A
Kailua Kona, HI 96740
(808)329-3314

Privacy Policy/HIPAA Compliance

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

We understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information. PHI includes individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment for such health care.

We use and disclose PHI about you for treatment, payment, and health care operations.

Treatment: We may disclose PHI to your insurance provider, our dentist(s), and other dental care providers for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seeks information from your insurance provider as to whether the service has been previously provided.

Payment: We disclose your PHI in order to fulfill our duty to check your coverage, determine your benefits, and secure payment for services provided to you. For example, we use your PHI in order to request process of your claims by your insurance provider.

Health Care Operations: We disclose your PHI as a part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of dental services that were performed.

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI. If you choose to sign

Please turn over and sign.

an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for treatment, payment, and health care operations).

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment, or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your PHI for treatment, payment, and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact us at the address listed above. You may also send a written complaint to the U.S. Department of Health and Human Services to 200 Independence Ave SW, Washington, DC 20201.

Our Legal Duty We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or concerns, please contact our office.

My signature below constitutes my acknowledgement that I have been provided with a copy of our Privacy Policy/HIPAA Compliance notice.

Name of Patient (Please Print) _____
Date

Signature of Patient or Legal Representative (Relationship) _____
Date

This authorization gives Dr Fred Gaeta and staff permission to speak to “close family members: regarding my medical information and treatment: circle one YES / NO

If YES, ADDITIONAL INDIVIDUALS YOU AUTHORIZE TO COMMUNICATE WITH US:

Name _____ **Relationship** _____

Name _____ **Relationship** _____



Fredric C Gaeta DDS

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to the success of your family treatment. Part of the commitment is your understanding and responsibility for the payment of your account balance.

Our basic financial policy is the following:

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR FINANCIAL COORDINATOR

WE ACCEPT CASH, CHECK, MONEY ORDERS, VISA/MASTERCARD, DISCOVER, AMERICAN EXPRESS AND SPECIAL FINANCING THROUGH SPRINGSTONE PATIENT FINANCING, CARECREDIT OR CITI HEALTH

ADULT PATIENTS

Adult patients are responsible for full payment at the time of service unless specific arrangements are made prior to the start of treatment.

MINOR PATIENTS

The adult accompanying a minor and the parents/guardians are responsible for full payment at time of service.

REGARDING INSURANCE

Participating insurance plans: The patient co-pay is required in full at time of service. We will accept assignment of *participating insurance plans* and will submit dental claims on our patient's behalf.

Non-participating insurance plans: Full payment is required at the time of service and we will submit a refund for payment from a *non-participating insurance company* back to our patients in a timely fashion. We are not able to pre-determine or bill for insurance benefits only.

Treatment quotes given are estimates only and are based on the insurance information you provide to us. A pre-treatment estimate will need to be submitted to your insurance company to determine the schedule of benefits for the services to be rendered.

Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Any insurance claim not settled within 90 days will be due in full. It is your responsibility to pay our practice in full for the treatment invoice.

Please be aware that some and perhaps all of the services provided may be non-covered services. You are responsible for the entire balance no matter what the outcome is with your insurance provider.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for the quality of the treatment that is rendered. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates. We will do all that is reasonable and proper to have you receive the maximum insurance benefits you are entitled to.

PATIENT RESPONSIBILITY AND ADDITIONAL TERMS

Accounts unpaid after 60 days from day of service are subject to a delinquent fee of \$25.00. Furthermore the unpaid balance is subject to a 1 ½% monthly (18% Annual) finance charge. If we have to submit your unpaid account to a collections process you will be responsible for all charges our practice incurs; including collection fees, court costs and reasonable attorney’s fees.

MISSED OR LATE APPOINTMENTS/RETURNED CHECKS

When you make an appointment with us we consider your time as “confirmed” or reserved. Should a scheduling conflict arise, please give our office at least two business days notice so that we may reschedule you properly as well as serve our other patients. Unless appointments are cancelled/rescheduled at least 48 hours in advance, our policy is to charge for missed appointments. You will be charged a minimum \$50.00 **non-refundable** fee. Showing up 30 minutes late for a scheduled, confirmed appointment will carry the same \$50.00 **non-refundable** fee. Any returned check will carry a \$30 fee.

Thank you for understanding our ***Financial Policy***. Please let us know if you have any questions or concerns.

I have read this ***Financial Policy***. I understand and agree to the terms of the ***Financial Policy of the office of Fredric C. Gaeta DDS***.

X _____
Signature of Patient or Parent of Minor Patient

Date _____

X _____
Signature of Person Financially Responsible for Account if
different from the Adult Patient signed above.

Date _____