TIME 11:25 AM ERIC G. UNGER, DDS PC DATE 11/8/2012

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	*Venereal Disease* ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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 IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

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 that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Privacy Officer
Eric G Unger DDS PC
161 Old Schoolhouse Lane
Mechanicsburg Pa 17055
717-697-4002

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement

ERIC G UNGER DDS PC
161 OLD SCHOOLHOUSE LANE
MECHANICSBURG PA 17055

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

ERIC G UNGER DDS PC
JEFF SHANNON DMD
TATIANA GRAHAM DDS
OFFICE AND FINANCIAL POLICY

Effective May 15, 2003

Financial Policy

Fees, co-payments and deductibles are due at the time of service. Patients who carry dental insurance should remember that professional services are rendered to the patient and not the insurance company. Plans differ as to what is covered and what is not covered and to what extent fees are paid. All insurance plans have yearly maximum benefit payouts for all dental services in and out of this office. The patient is responsible for keeping track of how much benefit is left in their plan. We will assist you as best we can. We will not enter into disputes with your insurance carrier as to policy provisions of what is a covered service and what is not covered. We will provide your insurance company with only factual information regarding your care. The ultimate responsibility of payment for services rendered is with the patient or responsible party.

For New Patients to the Practice with Insurance: If when you made your appointment you did not give your insurance information (Insurance company name, ID, Group number and telephone number), and/or we cannot verify coverage, payment will be due at the time of service. If you have not given this information to us please contact us as soon as possible so we may verify your coverage.

There will be a $5.00 billing fee for statements that are sent for payments, co-payments or deductibles not paid at the time of service. As an example: If you are in for treatment and the Fee is $100 and you do not pay at the time of service you will receive a statement from us for $105. For those patients with insurance: If your fee for services that day is $100 and we estimate your insurance will pay $80, your co-pay due the day of service is $20. If you do not pay at the time of service, you will receive a statement from us for $25. However if you pay the estimated co-pay of $20 and once we receive the insurance payment your actually co-pay should have been $22, we will send you a statement for the additional $2 and there will be no additional billing fee.

For insurance and non-insurance patients: If fees are not received within 30 days of receipt of our statement and a new statement is sent to you, there will be a $5.00 rebilling fee. There is a $20 fee for returned checks.

Overdue Accounts: If payment for services is not received within 90 days your account will be turned over to a collection agency. There will be a 25% fee added to your account to cover the cost of the collection agency fee. If your account has been turned over to a collection agency we will no longer schedule you in our practice.

BROKEN OR LATE CANCELLATION POLICY

Appointments are times set aside specifically for your care. Failures to show up for your appointment or giving short notice of cancellation does not allow us time to fill this open appointment with another patient waiting for care and may compromise the continuity of your care. We offer appointments during the day, evening and Saturdays. The evening and Saturday appointments are considered Prime Time. If you miss or cancel these appointments repeatedly we may not schedule you again during these prime appointment times.

There is a $45-65 fee (based on time appointed) for broken/missed, or late cancellation of hygiene (cleaning/exam) appointments. There is also a fee for broken/missed or late cancellation of appointment with doctor. This fee varies depending on the amount of time set aside for your care (the minimum fee is $45). This fee must be paid prior to any new appointments being scheduled. 24 hour notice is required for Tuesday, Wednesday and Thursday appointments. Saturday and Monday appointments should be rescheduled by the previous Thursday by 5:00p.m.

Patients who repeatedly miss appointments or cancel with less than 24 hours notice may be dismissed from the practice. We will continue to see you for emergency care for 30 days until you have established yourself with another practice.

PATIENT NAME :_____PATIENT (parent/Guardian) Signature_____

Date:_____

161 Old Schoolhouse Lane Mechanicsburg Pa. 17055 717 697-4002

DENTAL AND PERSONAL QUESTIONNAIRE

NAME _____ Date _____

1. What prompted you to seek dental care at this time? _____
2. How long since your last dental examination? _____
3. What was done at that time? _____
4. When were x-rays taken? Complete series _____ Panorex _____ Bitewings _____
5. What has kept you away for so long (if longer than 1 year)? _____
6. Do you feel you've had good dental treatment in the past? _____
7. Why have you decided to switch dentists? _____
8. Name of former dentist? _____
9. How often do you have your teeth examined and cleaned? _____
10. How often do you brush? _____ Type of brush? _____ Cleaning aids? _____
11. Do you floss? _____ How often? _____
12. Are you missing any teeth? _____
13. Why were they lost? _____ Were they ever replaced? _____
14. What type of replacement was recommended (bridge, partial, implant)? _____
15. Were you offered a choice of treatment? _____
16. How do you feel about the replacement (appearance, function, confidence)? _____
17. Do you have any difficulty adjusting to the replacement? _____
18. Are your teeth sensitive to hot, cold, or sweets? _____
19. Do your teeth hurt while chewing? _____ Which ones? _____
20. Do you chew on only one side of your mouth? _____ If so, why? _____
21. Do you trap food between any of your teeth? _____ Which ones? _____
22. Do your gums ever bleed, feel tender, or irritated? _____
23. Do you have any unhealed injuries, inflamed areas, growths or sore spots in your mouth? _____
24. Are you troubled with bad breath? _____
25. Have you ever had pyorrhea or periodontal disease? _____
26. Have you ever had any type of gum treatment? _____
    When? _____ By whom? _____
27. Have you ever had orthodontic treatment? _____
28. Does your jaw get tired, sore, tender? _____
29. Do you suffer from headaches? _____ Earaches? _____
30. Does your jaw click, pop, or get stuck? _____
31. Do you clench or grind your teeth? _____
32. How do you feel about the appearance of your teeth? _____
33. Are you interested in bleaching? _____
34. Do you mind metal showing when you talk or smile? _____
35. Do you prefer white fillings? _____
36. How do you feel about dentures? _____
37. Have you had local anesthetic? _____ Nitrous oxide sedation? _____
    Any problems? _____
38. Do you have a snoring problem and are you interested in appliance treatment? _____
39. What can we do to make your treatment more pleasant? _____

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ (FIRST / MI / LAST) DATE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ *SS#/SIN* _____ *DATE EMPLOYED* _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

ITEM 07-0516707/2/7000

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER