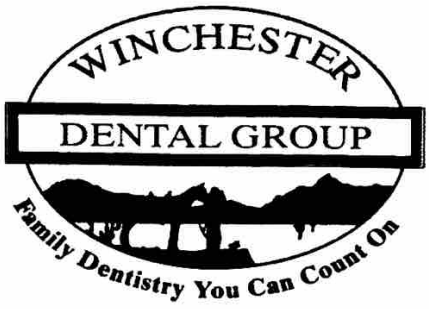


I, _____, acknowledge that I received from Winchester Dental Group/Andrew S. Arriola D.D.S. a copy of the Dental Materials Fact Sheet dated July 2004.

Patient Signature **Date**

The following document is the Dental Board of California's Dental Materials Fact Sheet. The Department of Consumer Affairs has no position with respect to the language of this Dental Material Fact Sheet; and its linkage to the DCA web site does not constitute an endorsement of the consent of this document.

WINCHESTER
DENTAL GROUP
Family Dentistry You Can Count On

Dear Patient:

Our credit policies have been established to ensure that the best services can be provided to you and your family and any misunderstanding can be avoided.

Our professional services are rendered to the patient and not the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor. We will not provide services on the assumption that the charges will be paid for by the insurance company. With or without insurance coverage, you are responsible for full payment of your bill.

I understand that any expected payment from my insurance company is an **ESTIMATE** only and that no balance shall be carried by The Winchester Dental Group. If the above-agreed estimate is under-estimated, payment will be made within 15 days of receiving notice of balance due. I also understand that I am responsible for any portion not covered by my insurance at the day the services are rendered. If I do not have coverage under dental insurance, payment in full is due at the time services are rendered. I further understand in the unlikely event that my account balance is delinquent for 30 days, finance charges will accrue at the annual rate of 18%, and my account(s) will be referred to an attorney for collections. In the event that this happens, I agree to pay all reasonable attorney fees and the outstanding balance due.

For your convenience, our office has made arrangements with Dencharge, Healthcare credit and American General Finance, Inc. to offer monthly payments to our valued customers.

Please indicate the manner you wish us to handle your account:

1._____I will pay cash the day of treatment.

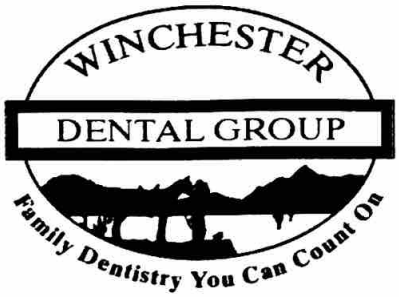
2._____I have insurance and will pay my estimated portion the day of treatment.

3._____I have insurance and elect to apply for Dencharge, Healthcare credit or American General.

4._____I have no insurance and would like to apply for Dencharge, Healthcare credit or American General.

_____ _____

Patient or Guardians signature Date



MISSED APPOINTMENT POLICY

This is to inform you of our Missed Appointment Policy. We realize that appointments can not always be kept due to various circumstances. However, when an appointment is missed and the patient does not notify our office, the doctor has lost that time and some other patient who is in need of treatment is unable to use the time reserved for you.

Trying to accommodate every patient's individual schedule can be difficult, but we always try to do our best. We work very hard to stay on schedule so that our valuable patients will not spend time in our reception area waiting for an appointment.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When appointments are missed or cancelled that time is permanently lost.

We ask that when you schedule an appointment, you make every effort to keep that commitment. We understand personal emergencies sometimes occur and we always take that into consideration when receiving a last minute cancellation.

If you find that you can not keep your scheduled appointment, we ask you to provide a minimum of twenty-four hours notice to us so that we may schedule another patient in need of treatment. If a notice is not received, a broken appointment fee will be billed to your account.

Therefore, we would appreciate your assistance by notifying the office as soon as possible if you can not keep your appointment. If you have any questions regarding this policy please do not hesitate to contact us. We sincerely appreciate your understanding and cooperation with this matter.

I have read and understand the implemented policy for this office.

_____ _____

Signature of patient/responsible party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Andrew Arriola, D.D.S.

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

Andrew S. Arriola, D.D.S.
and Associates

WINCHESTER DENTAL GROUP
Family Dentistry You Can Count On

WELCOME TO WINCHESTER DENTAL GROUP

Our entire team is dedicated to providing the highest quality and most gentle care to you and your family. It is important for us to understand your needs and concerns about dental treatment so that we may serve you better. Please feel free to add any comments that you believe may assist us in providing ideal dental care for you.

The WINCHESTER TEAM

PATIENT INFORMATION

NAME _____ (LAST) MR. MRS. MS. DR. (Circle) _____ (FIRST) _____ (MIDDLE) _____ (PREFERRED NAME OR TITLE)

ADDRESS _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

HOME PHONE _____ BIRTHDATE _____ SOCIAL SECURITY NO. _____

CELL PHONE _____ E-MAIL _____

IS IT OKAY TO CONTACT YOU AT THESE NUMBERS ❑ Yes ❑ No

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

RESPONSIBLE PARTY INFORMATION

NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE) _____ (MARITAL STATUS) _____ (RELATIONSHIP TO PATIENT)

ADDRESS _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ WORK PHONE _____

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

SOCIAL SECURITY NO. _____ BIRTHDATE _____ DRIVER'S LICENSE NO. _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

SPOUSES NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE)

SPOUSES EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

INSURANCE INFORMATION

INSURED'S NAME _____ BIRTHDATE _____ SOCIAL SECURITY NO. _____

INSURANCE COMPANY _____ GROUP NO. _____ LOCAL NO. _____

INSURANCE CO. ADDRESS _____

DO YOU HAVE DUAL (SECONDARY) COVERAGE? ❑ Yes ❑ No; If yes, please complete the following:

INSURED'S NAME _____ BIRTHDATE _____ SOCIAL SECURITY NO. _____

INSURANCE COMPANY _____ GROUP NO. _____ LOCAL NO. _____

INSURANCE CO. ADDRESS _____

INSURED'S EMPLOYER _____

EMERGENCY INFORMATION

NAME AND ADDRESS OF NEAREST RELATIVE _____

NOT LIVING WITH YOU _____ PHONE _____

Financial arrangements will be made with you before any treatment is rendered. All emergency dental treatment, or any dental treatment performed without prior financial arrangements will be paid for at the time treatment is performed. Patients who carry dental insurance understand that all dental treatment provided is performed directly for the patient and that you or your responsible party are personally responsible for payment of all dental treatment. A service charge of 18% per annum will be charged on the unpaid balance of all accounts over 60 days. I understand that when appropriate, credit bureau reports may be obtained. I grant my permission to your office to telephone me at my home or my work to discuss matters related to this form or my dental treatment.

_____ _____
PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE TODAY'S DATE

PLEASE COMPLETE OTHER SIDE

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	❑ Yes ❑ No	Cough, persistent or bloody	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Arthritis, Rheumatism	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Skin Rash	❑ Yes ❑ No
Artificial Heart Valves	❑ Yes ❑ No	Do you wear contact lenses	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No
Artificial Joints / Pins	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Fainting or dizziness	❑ Yes ❑ No	Nervous Problems	❑ Yes ❑ No	Swelling of Feet or Ankles	❑ Yes ❑ No
Back Problems	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Bleeding abnormally, with		Headaches	❑ Yes ❑ No	Women:		Tonsillitis	❑ Yes ❑ No
extractions or surgery	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Are you pregnant	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Heart Problems	❑ Yes ❑ No	Due Date_____		Tumor or growth on	
Cancer	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Are you nursing	❑ Yes ❑ No	head or neck	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Type_____		Psychiatric Care	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Respiratory Disease	❑ Yes ❑ No	Weight Loss, unexplained	❑ Yes ❑ No
Congenital Heart Lesions	❑ Yes ❑ No	HIV Positive	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No	Smoke or Use Tobacco	❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No		

MEDICATIONS

List medications you are currently taking:

_____

_____

Have you ever taken Fen-Phen ❑ Yes ❑ No

Have you ever taken Redux ❑ Yes ❑ No

ALLERGIES

❑ Aspirin
❑ Barbiturates (Sleeping pills)
❑ Codeine
❑ Iodine
❑ Latex
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other_____

Blood Pressure	Date ___/___	Date ___/___	Date ___/___

MEDICAL INFORMATION

Are you now under the care of a physician ❑ Yes ❑ No For what condition _____

Have you ever had antibiotic or other premedication before dental treatment? _____

Do you have any type of prosthetic replacements such as valves, joints, etc? _____

DENTAL INFORMATION

When were your last dental xrays? _____

Are you having dental discomfort today ❑ Yes ❑ No

What treatment would you like today? _____

_____

Do your gums bleed when you brush or floss? ❑ Yes ❑ No

Do you have any concerns about the appearance of your teeth ❑ Yes ❑ No

Do you have any additional concerns or comments? _____

_____

How do you feel about the overall condition of your teeth and mouth?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you desire to become regular continuing care patient in our practice ❑ Yes ❑ No

Do you desire to have your mouth properly restored and disease and pain free ❑ Yes ❑ No

The most important concerns regarding my dental treatment are:

_____

Does any type of dental treatment make you nervous?

Please describe _____

Previous Dentist _____

Reason for changing:

_____

Have you ever had a problem with: Local Anesthetic ❑ Yes ❑ No Previous dental treatment ❑ Yes ❑ No Nitrous Oxide sedation ❑ Yes ❑ No

When was your last cleaning or periodontal therapy? _____

Dr. Reviewed Med. / Dent. Records

CONSENT FOR TREATMENT

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or if my medications change, I will accept responsibility to inform the doctor and other appropriate staff members at my next appointment. I hereby grant authority to the dentist or appropriate staff members in charge of the care of the patient whose name appears on this form to administer anesthetics, analgesics, sedatives, nitrous oxide sedation as may be advised for dental treatment. In addition, I give permission for the performance of such procedures and operations as may be recommended in the diagnosis and treatment of this patient. Should I fail to understand the purpose, procedures, or risks of any treatment to be performed, I will request clarification to my satisfaction. All treatment and services are rendered to the patient and accepted under the terms and conditions printed on the reverse side of this form.

SIGNED _____ **DATE** _____

RELATIONSHIP TO THE PATIENT _____