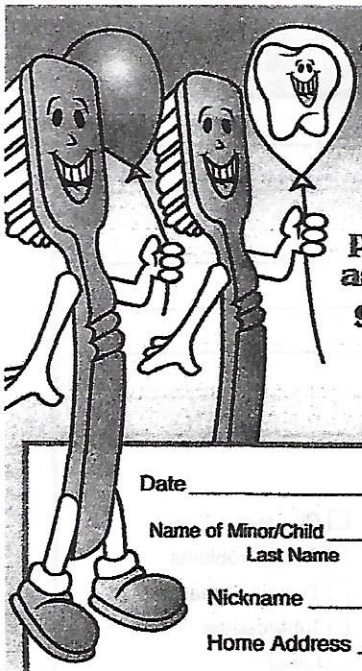
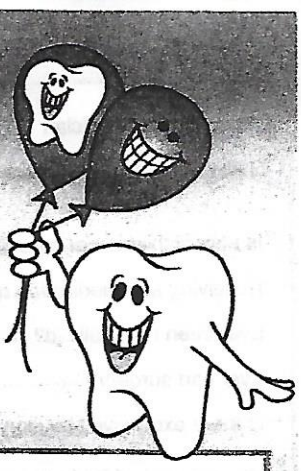


Welcome!



We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

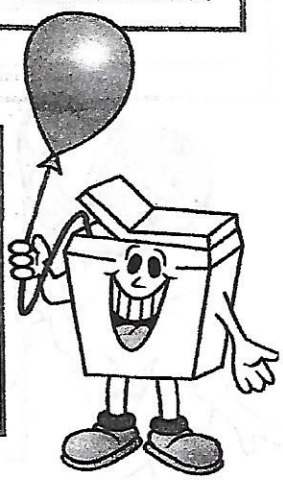
Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY



Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

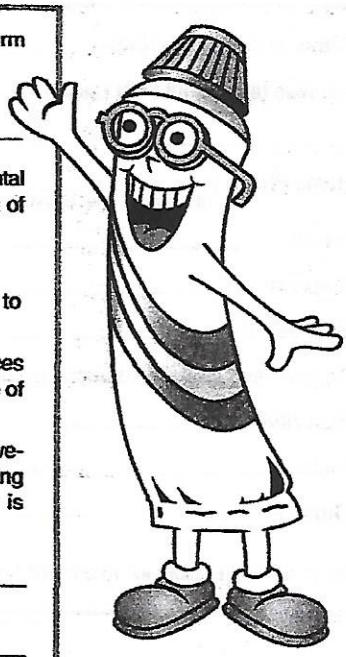
I certify that my dependent(s) is covered by insurance with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ *all insurance benefits, if any, otherwise payable to me for services* rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Parent, Guardian or Personal Representative — Relationship to Patient



UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

Beautiful Smiles Dentistry
151 N. Sunrise Ave Suite #1301
Roseville, CA 95661
(916)780-1955

Appointment Reservation Agreement

We provide our patients with scheduled appointment times. Please help us serve you and our other patients better by keeping scheduled appointments. Appointments that are missed or changed at the last minute are then unavailable to patients who need them. Therefore, a non-refundable fee of **$50.00** will be charged to your account. This fee cannot be billed to your insurance and therefore is your responsibility.

Our patients' time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. You can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

***Repeated cancelations or missed appointments will result in loss of future appointment privileges.**

***Patients who arrive 15 minutes late for their appointment may need to be rescheduled.**

***Appointments not confirmed via text, email or phone by 8am the day before your appointment date may result in the cancelation of your appointment.**

We would like to take this opportunity to welcome you to our office and assure that we will do our utmost to provide you the best care possible.

I have read and understand the above office policy. I have been provided with the answers to any questions I have at this time.

Patient Signature _____ Date: _____
(Patient or guardian if minor)

Beautiful Smiles Dentistry
151 North Sunrise Ave., Suite #1301
Roseville, CA 95661
916.780.1955

IBTISAM RASHID, D.D.S
HANA RASHID, D.D.S.

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability act of 1996 ("HIPPA") requires that, effective April 14, 2003 we provide you with a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. We ask that you review it carefully, as the privacy of your health information is important to us. We are required to ask you to sign a one-time acknowledgement that you received this summary.

Dr. Rashids practice revises these policies and procedures as necessary and appropriate to remain in compliance with HIPAA and state law. Changes in law and changes in our procedures can lead to a revision of these written policies and procedures. Staff must comply with the current policies and procedures.

Uses of Protected Health Information

We are permitted to use your PHI for treatment purposes, payments and healthcare operations:

TREATMENT- We may use or disclose your health information to a physician, or other healthcare provider providing treatment to you.

PAYMENTS - We may use or disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS - We may use or disclose your health information to conduct our business and evaluate the quality and efficiency of our processes. We have put into effect safeguards to protect the privacy of your health information. However, there may be incidental disclosure of limited information, such as, overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of practice. HIPPA recognizes that such disclosures maybe extremely difficult to avoid entirely, and considers them permissible.

YOUR AUTHORIZATION - 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 is 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**.** We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

UNSECURED EMAIL- We will not send you unsecured emails pertaining to your health information without your prior authorization.

CHANGE OF OWNERSHIP- If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

REQUIRED BY LAW- We may use or disclose your health information when we are required to do so by law.

APPOINTMENT REMINDERS- We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate 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 for a full explanation of our fee structure.

DISCLOSURE ACCOUNTING -You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

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 of how payments will be handled under the alternative means or location you request.

~AUTHORIZATION TO RELEASE YOUR INFORMATION~

I, (patient's or guardian's name)_____ authorize the following

individual(s)____BEAUTIFUL SMILES DENTISTRY___to use or get copies of my dental/health records.

Patients Signature_____ **Date**___/___/_____

I, _____ have received a copy of Dr.Rashid's Privacy Practices.

{Signature} _____ {Date}_____

FOR OFFICE USE ONLY

Could not obtain acknowledgement for the following reasons:_____

_____

Beautiful Smiles Dentistry
151 N. Sunrise Ave Suite #1301
Roseville, CA 95661
(916)780-1955

Financial Policy and Insurance Benefits

(Please initial after each paragraph)

I am responsible for providing Beautiful Smiles Dentistry with insurance information that is correct and current. I consent to release any information necessary to an insurance company or 3rd party payer for purposes of payment. I authorize payment of insurance or 3rd party payer to Beautiful Smiles Dentistry for services rendered. _____

I undertake a personal obligation and responsibility for my account. I am responsible for knowing my insurance benefits._____

I understand that the benefit information collected over the telephone from my insurance company is not a guarantee of payment. _____

I understand that my portion will be collected at the time of service and is only an estimate. I understand that the actual amount of funds reimbursed to Beautiful Smiles Dentistry by my insurance company may be less or more than the original estimate._____

I understand that the amount not covered by my insurance company is my responsibility and is due in full at the time I receive my statement. _____

I understand that there is the option of a financial payment plan, based on approved credit, with *CareCredit* or *Lending Club* offered to me through Beautiful Smiles Dentistry. _____

Patients without insurance are requested to pay for services as rendered._____

I have read and understood the above office policy. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

Signature of Patient _____ Date _____
(Patient or guardian if minor)