CONSENT FOR SERVICE

Welcome to our practice!

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice requires reimbursement on the part of each patient for the costs incurred in their care. Financial responsibility for each patient must be determined before treatment.

All emergency dental services, or any dental services furnished performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Payment of the entire fees due remains the sole responsibility of the patient.**

I understand that the fee estimates listed for dental treatment can only be extended for a period of six (6) months from the date of the patient's examination.

In consideration for the professional services rendered to me at Exquisite Dentistry, I agree to pay the reasonable value of these services to Exquisite Dentistry, or its assignee at the time services are rendered. I further agree that a waiver of any breach at any time for any condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees in the cost of collecting fees for services rendered.

I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Printed Name of Patient, Parent or Guardian   Date   Relationship to Patient

Signature of Patient, Parent or Guardian   Date   Contact Phone Number

CANCELLATION POLICY 48-hour Required Notice

Your appointment time is valuable and is reserved specifically for you. We thank you for your consideration in honoring your appointment time. We understand life is busy for all of us and we are happy to reschedule your appointment if needed. However, without a 48-hour notice, we may charge a **cancellation fee of $100**. Please make every effort to avoid this charge by giving us plenty of notice to fill your reserved appointment time.

I UNDERSTAND THE 48-HOUR CANCELLATION POLICY AND AUTHORIZE THAT I MAY BE CHARGED A $100 CANCELLATION FEE:

____

PRINTED NAME

____

Signature of Patient, Parent or Guardian Date

Your Name: ___________________________________ Date: _____ / ______ / _______

Please take some time to complete the following questions. Your feedback will help us better serve you and others in the future.

What did you like or dislike about your last dental office? _____________________________

What would you like to change about your smile if you could? _________________________

Please rate how you feel about the appearance of your smile? (select your answer)

_ I like it very much _ I like it _ It's Okay _ I would like to change it

Select any of the following that you are interested in learning about:

_ Whitening _ Tooth colored fillings _ Porcelain Veneers & Crowns _ Invisalign

Please tell us about how you found us:

Family, Friend, or Colleague?
Can we have their name so we can thank them? __________________________________

Did you use your Insurance Provider Directory? _ Yes _ No

If you answered yes, did you do research on the Internet after finding us in your Provider Directory? _ Yes _ No

Did you use any of the sites below to research our practice? (Please select all that apply)

_ Google _ Yelp _ Google Places _ Facebook _ Twitter _ Groupon

Any Others? ________________________________

If you found us on by Internet, what did you search for?
(Please list the keywords you used to search for us)

____

Did you visit our website? _ Yes _ No

If Yes, did it help you make a decision about us? _ Yes _ No

What was the most helpful? ____

Patient Information

Patient Name: ____ Date: _____ / _____ / _____

Nickname: _________________________ Date of Birth: ____ / _____ / _____ Social Security: _____ - _____ - _____

Male Female Married Single Domestic Partnership Divorced Widowed

Mailing Address: ____ Apt: _________________

City: ____ State: _______________ Zip: _________________

Cell Phone Number: ____________________________________ Alt Number: ________________________________

Email: ____

Would you like to receive email reminders? Yes No Text Reminders? Yes No

Employer Name: ____ Occupation: ____________________________

Responsible Party Information (if other than patient)

Name: ____ Relationship to Patient: ________________

Date of Birth: ____ / _____ / _____ Social Security: _____ - _____ - _____

Billing Address: ____ Apt: _____________________

City: ____ State: _______________ Zip: _________________

Cell Phone Number: ____________________________________ Alt Number: ________________________________

Insurance Information

Policy Holder Name: ____

Date of Birth: ____ / _____ / _____ Social Security: _____ - _____ - _____

Insurance Company Name: ____

Insurance Company Provider Phone Number: ____

EXQUISITE DENTISTRY

MEDICAL HISTORY

Patient Name: ____ Date of Birth: ____ / _____ / _____

Although we primarily treat the area in and around your mouth. The state of your Oral Health can affect your entire body. Health problems that you may have, or medication that you may be taking, could also have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions: (If your are using Acrobat Reader to type this form, not all fields can be completed.)

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 If yes, please explain: ______________________
Are you on a special diet? _ Yes _ No If yes, please explain: ______________________
Do you use tobacco? _ Yes _ No If yes, please explain: ______________________
Do you use controlled substances? _ Yes _ No If yes, please explain: ______________________
Women: Are you Pregnant/Trying? _ Yes No Taking oral contraceptives? _ Yes _ No Nursing? _ Yes _ No

Are you allergic to any of the following? _ Aspirin _ Penicillin Codeine _ Acrylic _ Metal _ Latex _ Local Anesthetics

_ Other Please Explain: ____

Do you have, or have you had, any of the following? (Questions not highlighted cannot be completed by Acrobat Reader)

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

Have you ever had any serious illness not listed above? _ Yes _ No If yes, please explain: ______________________

____

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 or GUARDIAN ______________________________ DATE ____ / _____ / _____

Reviewed by Doctor: ______________________________ DATE ____ / _____ / _____

EXQUISITE DENTISTRY

Patient Photography / Model Release

In consideration of my engagement as a model, and for other good and valuable consideration herein acknowledged as received, I hereby grant the following rights and permissions to Jose Alexie Aguil DDS, Inc., its photographer, legal representatives, and assigns, and those acting with authority and permission. They have the irrevocable, perpetual and unrestricted right and permission to take, use, re-use, publish, and republish photographic portraits or pictures of me or in which I may be included, in whole or in part, or composite or distorted in character or form, without restriction as to changes or alterations, in conjunction with a fictitious name, or reproductions thereof in color or otherwise, made through any medium, and in any and all media now or hereafter known, specifically including but not limited to internet media and distribution over the internet for illustration, promotion, art, editorial, advertising, trade, or any other purpose whatsoever. I specifically consent to the digital compositing or distortion of the portraits or pictures, including without restriction any changes or alterations as to color, size, shape, perspective, context, foreground or background. I also consent to the use of any published matter in conjunction with such photographs. I hereby waive any right that I may have to inspect or approve the finished product or products and the advertising copy or other matter that may be used in connection with them or the use to which they may be applied.

I hereby release, discharge, and agree to hold harmless Jose Alexie Aguil DDS, Inc., legal representatives, and assigns, and all persons acting under its permission or authority or those for whom may be acting, from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of such photographs or in any subsequent processing of them, as well as any publication of them, including without limitation any claims for libel or violation of any right of publicity or privacy.

I hereby warrant that I am of full legal age and have the right to contract in my own name. I have read the above authorization, release, and agreement, prior to its execution, and I am fully familiar with the contents of this document. This document shall be binding upon me and my heirs, legal representatives, and assigns.

X

SIGNATURE (Patient, Parent, or Guardian) DATE

NAME

ADDRESS (Line 1)

ADDRESS (Line 2)

PHONE EMAIL

EXQUISITE DENTISTRY – 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 laws 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 as of November 5, 2013, 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 and to maintain all terms permitted by applicable laws. We reserve the right to make changes in our privacy practices and the new terms of our notice will be 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 the notice and make the new notice available to you.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for our services to a third party responsible for the collection of funds.

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 qualification of healthcare professionals, evaluating practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities. Operations also include using your name in the presence of other individuals that might see and/or hear your name while at our office. We may use your information or disclose your health information, only as necessary, to contact you by email, text or telephone in order to discuss an appointment, treatment plan, financial plan or other reason pertinent to providing the services you have asked us to provide.

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 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.

6227 Wilshire Blvd • Los Angeles CA 90048 • (323) 525-0005 • www.ExquisiteDentistryLA.com

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 a family member (including identifying or locating), your personal representative or another person responsible for you care, of your location, your general condition, or death. If you are present, then prior to 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 the 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 use your health information for internal marketing communications only when you authorize email or text communications.

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 and safety or the health and 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, email, text 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 do so. Your request must be 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. If you request copies, we will charge you $25 to locate and copy your health information and mail it to you. If you request an email copy of your records, there will be no charge. 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 fees.

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 the special cases already outlined in this notice.)

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location requests.

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 and may request documentation to support such a change.

Electronic Notice: If you receive this notice on our website or by email, you are entitled to receive this notice in written form at our office.

QUESTIONS, COMPLAINTS, AND CONTACT INFORMATION

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we make about access to 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 below. You also may submit a written complaint to the U.S. Department of Health and Human Services (DHHS). We will provide you with the address to file your complaint with the DHHS upon request.

We support your right to the privacy and are fully committed to keeping it secure. Please give us the opportunity to correct the issue should one arise. We will not retaliate in any way if you choose to file a complaint with the DHHS or us.

Contact Officer: Privacy Manager
Telephone: 323-525-0005
Email: private@ExquisiteDentistryLA.com
Address:
Exquisite Dentistry
ATTN: Privacy Manager
6227 Wilshire Blvd
Los Angeles, CA 90048

I have received a copy of:

"Exquisite Dentistry - Notice of Privacy Practices"

**** You may refuse to sign this Acknowledgement ****

____
Printed Name

____
Signature DATE

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy, but it could not be obtained due to:

_ Individual refused to sign

_ Communication Barriers

_ Emergency Situation

_ Other: _______________