Welcome!

Each time you come to our office we want you to have a pleasant and wonderful experience.

Our goal is to see you promptly at your reserved time and to make the appointments as quick and easy for you as we can.

Your satisfaction and care is our top priority. We have an excellent staff that is highly trained and available to serve your every need.

To help us serve you and others as best we can we ask that you notify us 24 hours in advance if you will need to reschedule an appointment. We do understand that emergencies do come up and we take that into consideration. However, if you do not show to your appointment or do not call us to let us know that you will not be able to make it in; your account will be charged 20.00

We appreciate the opportunity to serve you. Please let us know if you have any special requests.

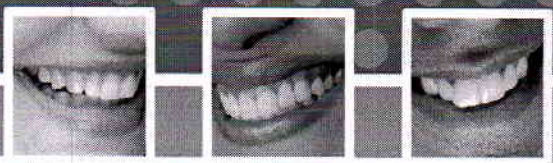
Dr. Tarek Safadi

_____ _____

Signature Date

Angel Smiles Dental PC
8159 East 109th Avenue
Crown Point, IN 46307

(219)663-6077
info@angelsmilesdental.com
www.angelsmilesdental.com



Patient Information

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Date of Birth_____ SS#_____

Gender: Male___ Female___ Status: Married___ Single___ Child___ Other___

Address_____

City_____ State_____ Zip_____

Email_____

Home Phone_____ Cell Phone_____

Employer/Occupation_____ Phone_____

Whom may we thank for referring you? _____

Insurance Information

Policy Holder_____ Date of Birth_____

SS#_____ Relationship to Patient_____

Insurance Company_____ Phone_____

ID # _____ Group # _____

Patient or Guardian Signature:

_____

Response Date: _____

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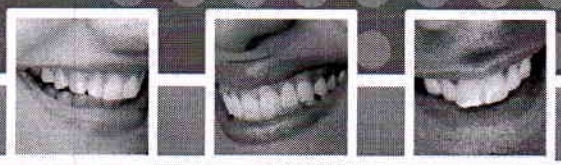

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Please check any of the following which may apply to you now or in the past:

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Allergies
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa
☐ Allergy-Metal	☐ Anemia/Excess Bleed	☐ Angina	☐ Arthritis
☐ Artificial Joints	☐ Artificial Valves	☐ Asthma	☐ Blood Disease
☐ Cancer	☐ Clench/Grind Teeth	☐ Dental Sensitivity	☐ Diabetes
☐ Dizziness	☐ Drug/Alcohol Depend	☐ Epilepsy/Seizures	☐ Fainting
☐ Freq. Dry Mouth	☐ Glaucoma	☐ Head Injuries	☐ Headaches/Migraines
☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur	☐ Heart Valve Disorder
☐ Heartburn	☐ Hepatitis	☐ High Blood Pressure	☐ HIV/AIDS
☐ Implants	☐ Jaundice	☐ Kidney Problems	☐ Liver Disease
☐ Lung Disease	☐ Mental Disorders	☐ Nervous Disorders	☐ Osteoporosis
☐ Pacemaker	☐ Pregnancy(Currently)	☐ Radiation Treatment	☐ Reflux
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Serious Illness
☐ Sinus Problems	☐ Stroke	☐ Thyroid Disease	☐ Tobacco Use
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

Please list all medications you are taking:

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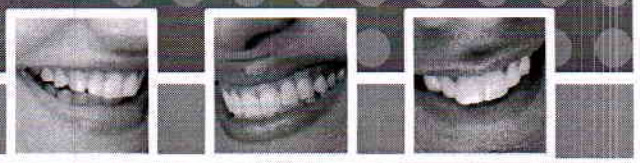

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Are you currently pregnant? If yes, when are you expecting? _____

◯ Yes ◯ No

Are you currently nursing?

◯ Yes ◯ No

Have you seen a physician or been hospitalized in the past year (including pregnancy)? If yes, please explain

Physician's Name and Phone

Have you ever had an allergic reaction to an anesthetic or drug such as penicillin, sedative, aspirin, latex, or metals? If yes, please explain

Are you taking or have you ever taken any medication to treat Osteoporosis (Fosamax, Reclast, etc.)? If yes, please explain

Patient or Guardian Signature: _____

Response Date: _____

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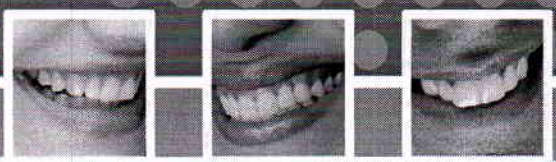

Informed Consent for Dental Treatment

Preliminary Consent for Treatment

I understand that I may have one or all of the following done today: Exam, X-rays, and Cleaning

Medications, Substances, and Medical Conditions

I have informed the dentist of any known allergies and/or medical conditions, including possible pregnancy. I understand that antibiotics, analgesics "Pain medicines", anesthetics, latex, and other substances can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, vomiting, and/or more severe allergic reactions.

Changes to Treatment Plan

I authorize my dentist UPON INFORMING me to make changes and/or additions to my treatment plan as necessary. I understand that during treatment it may be necessary to change or add procedures because of conditions found during treatment that were not evident during the initial examinations. Some of these changes are, but are not limited to, root canal therapy that is necessary following the placement of "deep fillings" or crowns recommended after placement of "large fillings".

Dental Benefits

I understand that treatment that my dentist recommends is based on what he determines is the best for my dental health, and not necessarily based on what an insurance plan will pay.

I understand that my insurance (if any) may not cover all aspects of my treatment plan and I will be financially responsible for any treatment not covered by the insurance plan.

I understand the treatment plan proposed to me is an estimate of insurance benefits and my actual coverage may differ due to frequencies limitations, clauses, coverage, incomplete information provided by my insurance company, etc.

I acknowledge that I am responsible for any balance remaining in the event that my insurance coverage is terminated.

Patient or Guardian Signature:

_____

Response Date: _____

Angel Smiles Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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:

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

I have received, read, and understand 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.*

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 operation. I also understand that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

Patient Name (print)_____DOB_____

Relationship to Patient_____

Signature_____Date_____

REQUEST FOR CONFIDENTIONAL COMMUNICATIONS

Home #_____ May we leave a message? Yes or No

Work #_____ May we leave a message? Yes or No

Cell # _____ May we leave a message? Yes or No

Email _____ May we send an email? Yes or No

May we send an appointment reminder text? Yes or No

May we leave a message that you need pre-medication? Yes or No

May we leave a message that you have a dental appointment? Yes or No

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices but was unable to do so as documented below.

Date_____Reason_____Initial_____