Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

✓ We are truly caring about our patients and want you to feel very comfortable with our entire staff.
✓ We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.
✓ We work with only one patient at a time, and do not double book. The time that you reserve with us is yours and yours alone.
✓ We strive to be thorough in everything we do, taking the time to be the best we can be.
✓ We are esthetics oriented, helping you look your best, while maintaining optimum comfort, function and health.

At your first visit, we will take the time to get to know you (and you, us) and discuss your dental needs and desires. We will perform a comprehensive dental evaluation and gather information to make a customized plan for you. This will take approximately 90 minutes.

Enclosed you will find our new patient information form. Please fill this out and bring it with you to your first appointment along a list of any medications that you take.

We look forward to meeting you.

Sincerely,

Bradley A. Blair, DDS and Staff

P.S. Please visit our website at www.blairdental.com to learn more about us!
Welcome to our office. We appreciate your selection of this office to serve your dental health needs. Our goal is to provide the very best possible dental care for our patients so that each of you may maintain optimum dental health throughout your lifetime. Please provide us with the following information so that we may get to know you better.

Date____________________

Name____________________________________Social Security Number____________________

Home Address________________________________City________________Zip____________

E-Mail Address_______________________________________________________________

Home Telephone_________________Work_________________Cell____________________

Occupation_______________________________Company Name________________________

Company Address______________________________________________________________

By what name do you wish to be called in our office?____________________________________

Birthday_______________Marital Status___________Name of Spouse____________________

Whom may we thank for referring you to our office?____________________________________

Are other family members patients here?______________________________________________

Who is your medical doctor?________________________________________________________

What in particular brings you to our office?____________________________________________

Method of payment:

___________Payment at time of visit
___________Mastercard or Visa
___________Dental Insurance. Name of Insurance Company________________________

Name of Insured________________________Birthdate of Insured________________SSN________

Company Name & Address____________________________

Do you have Dental Insurance Coverage other than your own?____________________________

Name of Insurance Company________________________

Name of Insured________________________Birthdate of Insured________________SSN________

Company Name & Address____________________________
For our patients with dental insurance, please remember that YOU ARE RESPONSIBLE FOR PAYMENT. Remember too that few insurance companies attempt to cover all dental costs. Some pay fixed allowances for certain procedures, others pay a percentage of the charge. It is your responsibility to pay any deductible, co-insurance, or other balance not paid for by your insurance.

**DENTAL HISTORY**

Date______________ Name________________________________________________________

Reason for Appointment___________________________________________________________

Do you desire complete and thorough dental care or treatment of a specific problem only?

_____________________________________________________________________________

Have you had regular preventive dental care in the past?_______________________________

When was your last dental appointment?___________________________________________

Do you feel that saving your teeth is worth the effort?_______________________________

Are you satisfied with the appearance of your smile?________________________________

If you could change anything about your smile, what would it be?_________________________

Do you care if metal fillings show?___________________________________________________

Have you ever had orthodontic treatment (braces)?_______________________________

Have you ever had any wisdom teeth removed?_______________________________________

Do you wear a removable partial or denture?_______________ Year made_______________

If yes, are you satisfied with it?___________________________________________________

Have there ever been any injuries to your mouth?____________________________________

Are your gums ever sore or do they bleed?_________________________________________ 

Do you have any loose teeth?_______________________________________________________

Have you ever been told that you have gum disease (pyorrhea)?________________________

Do you have any sore or sensitive teeth?___________________________________________

Do you ever notice sounds or pain in the jaw joint?__________________________________

Have you ever been told that you have a problem with your bite?________________________

Do you clench or grind your teeth?_________________________________________________
Have you ever had any trouble with previous dental treatment?___________________________

Do you have any other concerns that we should know about?_____________________________

MEDICAL HISTORY

Are you in good health?_____________________________________________________________

Are you in the regular care of a physician?____________________________________________

If so for what?____________________________________________________________________

Have you been in the hospital in the last 2 years?_____________________________________

Do you take any medications?_______________________________________________________

Do you use tobacco in any form?_____________How much?_______________________________

Are you allergic to any medications?__________________________________________________

Have you ever had any excessive bleeding problems?____________________________________

Have you ever had a bad reaction to a medication?_____________________________________

(Women) Are you pregnant now or trying?_____________________________________________

Have you had any of the following:

<table>
<thead>
<tr>
<th>Heart Trouble</th>
<th>Asthma</th>
<th>Seizures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fainting</td>
<td>Venereal Disease</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>Diabetes</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Heart Attack</td>
<td>Stroke</td>
</tr>
<tr>
<td>Heart Murmur</td>
<td>Liver Disease</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Cancer</td>
<td>Arthritis</td>
<td>Jaundice</td>
</tr>
<tr>
<td>Kidney Trouble</td>
<td>Rheumatic Fever</td>
<td>AIDS</td>
</tr>
</tbody>
</table>

Do you have any other health problems that we should know about?_______________________

_________________________________________________________________________________

Patient’s Signature_______________________________________________________________
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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:

_________________   __________   ________
The better we understand you, the better we can serve you. We don’t like to make assumptions or guess about what makes you tick. Please make a mark along each scale below to indicate your opinion or preference.

<table>
<thead>
<tr>
<th>I know a great deal about my dental condition</th>
<th>I know very little about my dental condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I like to be presented with fewer options</td>
<td>I like to be presented with more options</td>
</tr>
<tr>
<td>I tend to look at the details</td>
<td>I tend to look at the big picture</td>
</tr>
<tr>
<td>I prefer long-lasting solutions which may cost more</td>
<td>I prefer more temporary solutions at lower cost</td>
</tr>
<tr>
<td>I prefer to talk in technical terms with my dentist</td>
<td>I prefer to talk in non-technical terms</td>
</tr>
<tr>
<td>My insurance largely determines the extent of my care</td>
<td>I largely determine the extent of my care</td>
</tr>
<tr>
<td>I prefer to wait until I must act</td>
<td>I usually see no reason to delay care</td>
</tr>
<tr>
<td>I rely more on self-maintenance</td>
<td>I rely more on professional maintenance</td>
</tr>
<tr>
<td>I like newer and more modern techniques</td>
<td>I prefer tried and true methods</td>
</tr>
<tr>
<td>I favor a treatment-oriented approach to disease</td>
<td>I favor a cause-oriented approach to disease</td>
</tr>
</tbody>
</table>

In order of importance, I generally consider the following benefits (please rank 1 through 7 or 8):

- Comfort
- Appearance
- Peace of Mind
- Function
- Precision
- Durability
- Health
- Other ______________

In order of importance I generally weigh the following costs (please rank 1 through 5 or 6):

- Money
- Time
- Personal Effort
- Physical Discomfort
- Fear / Anxiety
- Other ______________

© ProSynergy Dental Communications
Seattle, WA (800) 848-8326
Facts About Dental Insurance

As an optimal-care dental practice, we strongly believe our patients deserve the best possible dental services we can provide. In an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

**Fact #1:** Your dental insurance is based upon a contract between your employer and the insurance company. Should questions arise regarding your dental insurance benefits, it is best for you to contact your employer or the insurance company directly.

**Fact #2:** Dental insurance benefits differ greatly from traditional medical health insurance benefits and can vary quite a bit from plan to plan. When dental insurance plans first appeared in the early 1970s most plans had a yearly maximum of $1000. Today, some 30+ years later, most plans still have an annual maximum of $1000. That the premiums remained the same, allowing for a conservative yearly rate of inflation, your yearly plan maximums should be in excess of $4500 today. Your premiums have increased, but your benefits have not. Therefore, dental insurance was never set up to cover your services 100%; it is only an aid.

**Fact #3:** You may receive a notification from your insurance company stating that dental fees are "higher than usual and customary." Insurance companies never reveal how they determine "usual, customary and reasonable" (UCR) fees. A recent survey done in the state of Washington found at least eight different UCR fee schedules for one zip code in the Seattle area. The fees are somehow determined by taking "a percentage" of an average fee for a particular procedure in a geographic area. Average has been defined as "the worst of the best" or "the best of the worst." *We do not provide average dentistry nor do we charge average fees.*

**Fact #4:** Many plans tell their participants that they will be covered "up to 80% or up to 100%," but do not clearly specify plan fee schedule allowances, annual maximums, or limitations. It is more realistic to expect dental insurance to cover 35 to 50 of major services. Remember, the amount a plan pays is determined by how much the employer paid for the plan. You get back only what your employer puts in, less the profits of the insurance company.

**Fact #5:** Many routine dental services are not covered by insurance companies. This does not mean they aren't necessary or appropriate, just not covered.

We feel that dental insurance can be a great benefit for many patients and want you to know we will do everything in our power to insure that you get every benefit dollar you are entitled to. However, the treatment we recommend and *the fees we charge will always be based on your individual need, not your insurance coverage.* The ultimate decision as to what will be done and how fast we proceed will always be made by you. Based on your decision, we will discuss the total cost of treatment and what assistance you can expect from your dental insurance. 'All arrangements are strictly between you and our office. The full responsibility for payment of services rendered will always be with you.
NOTICE OF PRIVACY PRACTICES
(DENTAL)

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 healthcare 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 Internet 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 to 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 a paper copy of this notice from us upon request.
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 January 1, 2002, 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 written complaint with our office, 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:

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