

Price's Corner 710 Greenbank Road, Wilmington, Delaware 19808
302.994.2582 fax 302.994.5151

People's Plaza 1200 Peoples Plaza, Suite 1260, Newark, Delaware 19702
302.834.7700 fax 302.834.5325

www.kirkwooddental.com

R.R. Christy, D.M.D.
D.C. Ehrenfeld, D.D.S.
E.S. Esbitt, D.M.D.
N.J. Punturieri, D.M.D.
A.L. Young, D.D.S.

Welcome

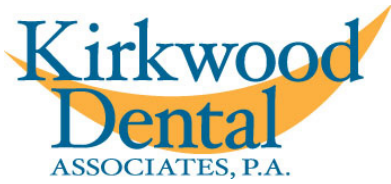
We would like to welcome you to our practice, and thank you for choosing Kirkwood Dental Associates to provide you services to ensure your dental health. We take pride in providing quality dental care in our friendly, family-oriented offices.

We have enclosed information about our policies and services. Also enclosed is a patient information sheet and a medical questionnaire, which you may complete and bring with you for your appointment or fax it back to one of our offices. If you have any questions, or if we could be of further assistance, please do not hesitate to call us.

We look forward to meeting you, and want to warmly welcome you to our family of patients.

Sincerely,

Kirkwood Dental Associates, P.A



Patient Profile

Please fill out this form completely. It will enable us to help you more effectively.
If you have any questions, please feel free to ask us, we will be happy to help you complete it.

R.R. Christy, D.M.D.
D.C. Ehrenfeld, D.D.S.
E.S. Esbitt, D.M.D.
N.J. Punturieri, D.M.D.
A.L. Young, D.D.S.

About You

Today's Date _____ Male Female
 Name _____ Age _____
 Date of Birth _____ SSN# _____
 Address _____

 City _____ State ____ Zip _____
 Single Married Divorced Widowed Separated
 Home Phone _____ Cell Phone _____
 Work Phone _____ Extension _____
 Email Address _____
 Employer _____
 Employer's Address _____
 Length of Employment _____ Occupation _____
 Other Immediate Family Members in Our Practice? _____
 Who May We Thank For Referring You? _____
 Dentist: Dr. Christy Dr. Ehrenfeld Dr. Esbitt
 Dr. Punturieri Dr. Young
 Last Dental Vist Date _____

Spouse / Significant Other

Their Name _____ Age _____
 Date of Birth _____ SSN# _____
 Employer's Address _____
 Work Phone _____ Extension _____

Person Responsible for Account

Name _____
 Home Phone _____ Work Phone _____
 Billing Address _____

 City _____ State ____ Zip _____
 Relationship _____ SSN# _____
 Employer _____

In the event of an emergency is there someone who lives near you that we may contact?

Name _____ Relationship _____
 Home Phone _____ Work Phone _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name _____
 Address _____

 City _____ State ____ Zip _____
 Phone _____
 Plan Effective Date _____
 Group, Plan or Policy # _____
 Insured's Name _____ Relationship _____
 Date of Birth _____ SSN# _____
 Employer _____

If Over 19 Years of Age and a Full-Time Student

Name of School _____
 City _____ State _____

Secondary Dental Insurance

Insurance Co. Name _____
 Address _____

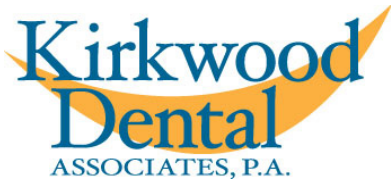
 City _____ State ____ Zip _____
 Phone _____
 Plan Effective Date _____
 Group, Plan or Policy # _____
 Insured's Name _____ Relationship _____
 Date of Birth _____ SSN# _____
 Employer _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information and have completed the above information. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any of the above information

I hereby authorize the release of information relating to my insurance claims
X _____
Patient Signature (or Guardian of Minor)

I hereby authorize payment of the group insurance benefits to Kirkwood Dental Associates, P.A.
X _____
Patient Signature (or Guardian of Minor)

Payment is due in full at the time of the treatment unless prior arrangements have been approved.



Dental /Medical History

I have reviewed this information and made necessary changes	
Initial	Date
_____	_____
_____	_____
_____	_____

Date _____
 Name _____ Date of Birth _____
 Date of last dental cleaning _____ Reason for visit _____
 Family Physician/Cardiologist _____ Doctor's Phone _____

1. Please check if you have or had any of the following health conditions:

- | | |
|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> HIV Positive / AIDS | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> High <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Artificial Joint Replacement | <input type="checkbox"/> Kidney Trouble <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> Blood Disorders such as <input type="checkbox"/> Anemia <input type="checkbox"/> Hemophilia <input type="checkbox"/> _____ | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation | <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Severe Infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach/Intestinal Ulcers |
| <input type="checkbox"/> Epilepsy <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Pacemaker <input type="checkbox"/> Stents <input type="checkbox"/> Shunts <input type="checkbox"/> Bypass date ___/___ | <input type="checkbox"/> Venereal Disease |

2. Are you taking any blood thinners? Coumadin Plavix Persantine Heparin Other _____

3. Do you require antibiotic pre medication for Heart Murmur Mitral Valve Prolapse Joint Replacement, date ___/___
 Other _____

4. Are you? Pregnant Nursing Taking birth control pills

5. Do you have frequent? Headaches Neck Pain Clicking in your jaw Jaw Pain

6. Do your gums bleed when you? Brush your teeth Floss

7. Do you have any other disease, condition or disability not listed? _____

8. Please list any surgeries you have had and an approximate date _____

9. Is there anything about your teeth you would like to change? Color Shape Bite Denture Fit Other

If other, please explain _____

DRUGS, MEDICATION AND FOODS

1. Are you taking any prescription medication or over the counter drugs? If so, please list name and condition it is taken for.

2. Have you had any allergies or side effects to any drugs or medications such as Novocaine Xylocaine Penicillin

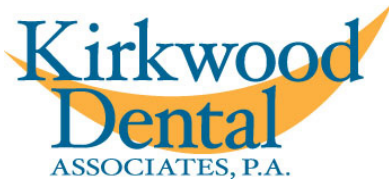
Tetracycline Codeine Aspirin Other _____

Foods such as Bananas Peanuts Other _____

Or Latex Fluoride Mouthwash Other _____

I certify that the above information is correct and give my permission for my physician to be contacted if necessary.

Patient Signature _____ Date _____



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 law 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 took effect on 4/15/2003 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, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice 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 this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example;

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

Payment: 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 in connection with our healthcare operations. healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us a 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 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.

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 (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or 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 a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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 not use your health information for marketing communications without your written authorization.

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 or safety or the health or safety of others.

NOTICE OF PRIVACY PRACTICES (CONT.)

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 voice mail 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 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 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. You may also request access by sending us a letter to the address listed at the end of this Notice. If you request copies, we will charge you \$0.25 for each page. \$25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative 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 using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 an emergency).

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

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.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of 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 at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

CONTACT OFFICER: Patricia Cornette

TELEPHONE: 302-994-2582

FAX: 302-994-5151

EMAIL: info@kirkwooddental.com

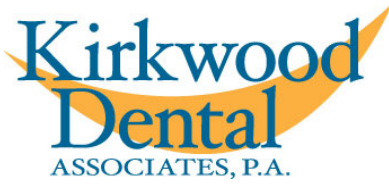
ADDRESS: 710 Greenbank Road, Wilmington, Delaware 19808

©2002 American Dental Association

All Rights Reserved

Reproduction of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)



Price's Corner 710 Greenbank Road, Wilmington, Delaware 19808
302.994.2582 fax 302.994.5151

People's Plaza 1200 Peoples Plaza, Suite 1260, Newark, Delaware 19702
302.834.7700 fax 302.834.5325

www.kirkwooddental.com

R.R. Christy, D.M.D.
D.C. Ehrenfeld, D.D.S.
E.S. Esbitt, D.M.D.
N.J. Punturieri, D.M.D.
A.L. Young, D.D.S.

Payment Policies

The following is the payment policy for Kirkwood Dental Associates, P.A.. This policy applies to all of our patients. If you have insurance coverage, our staff will discuss with you the amount your insurance carrier is estimated to pay, and the following policy applies to the part of the fee that is not covered by your insurance. Please note that if your insurance company will only send the check to you, you will be expected to pay the fees in full at the time of service, unless other arrangements have been made through our billing office.

Payment at the time of service

- Cash, check, Visa, MasterCard, Discover, American Express or money order may be used to make payment
- Procedures, which exceed \$200, will qualify for a 5% discount if the fee is paid in full when beginning the procedure (teeth whitening and CareCredit excluded).

Payment Plan (for fees in excess of \$200)

- Requires that only half of the charge be paid at the start of the procedure. The remaining balance to be paid in two equal monthly payments, unless other arrangements have been made through our billing office.

Financing through CareCredit

- The CareCredit application process is between the credit provider and the patient. Kirkwood Dental will supply the paperwork and initiate the contact while you are here, but we have no other influence in the process. Approval, payment arrangements, and billing questions are handled directly by CareCredit.

Thank you for your consideration and support. We appreciate your business, and want to make your dental experience as pleasant as possible.

Sincerely,

Kirkwood Dental Associates, P.A.