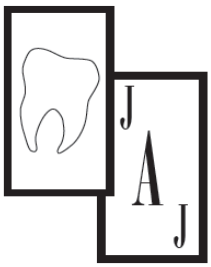


Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

Acquaintance Form

Date: _____

First Name: _____MI:_____ Last Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Home Phone # _____Cell # _____ Work #_____

E-mail Address_____

What are the most convenient method(s) to confirm your dental appointments?

□ Home Phone □ Cellular Phone □ Office Phone □ E-mail □ Text Message

Date of Birth: _____ Social Security #: _____

Employer: _____Occupation: _____

Business Address: _____

Whom May We Thank For This Referral: _____

Married:_____ Single:_____ Widowed:_____ Divorced:_____ Committed Relationship:_____

Person Responsible for My Account: _____

Relationship to those responsible for My Account: _____

Contact Information for Those Responsible for My Account:

Mailing Address: _____

_____

City/State/Zip: _____

Telephone: _____

Dental Insurance Information:

Do you have Dental Insurance Benefits: Yes:_____ No:_____ If Yes, Please Complete Below:

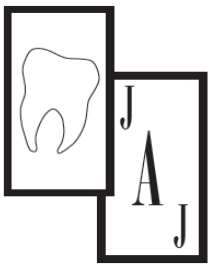
Dental Insurance Company: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder Birth Date: _____ Policy Holder Social Security Number: _____

Policy Holder Employer: _____

Signature:_____ Date: _____



Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

Health History Form

Your (Previous) Dentist's Name:_____ Last Visit Date:_____

Telephone # _____ Address: _____

Do you recall your last dental cleaning visit? Yes:_____ No:_____ If Yes, Please indicate date? _____

Do you have current radiographs (x-rays) Yes:_____ No:_____ If Yes, Please indicate date taken? _____

Are you currently having any urgent dental needs (pain, discomfort , area of mouth, how long, etc.)

If Yes, Please explain: _____

_____

_____

Your Physician's Name:_____Telephone # _____ Last Visit Date:_____

Are you currently being treated by a physician? Yes:_____ No:_____

Are you allergic to any medications? Yes:_____ No:_____

If Yes, What? _____

Any recent illness or changes in your health? Yes:_____ No:_____

If Yes, What? _____

Are You Regularly Pre-Medicated with Antibiotics for a Dental Visit? Yes:_____ No:_____ If Yes, What? _____

Are You Currently Taking Any Blood Thinning Medications? Yes: _____ No: _____ If Yes, What? _____

Are you currently or have you previously taken oral bisphosphonates (ex. Fosamax)

Yes: _____ No: _____If Yes, for how long? _____

Have you noticed any unexplained weight loss or weight gain? Yes:_____ No:_____

Do you experience unrestful sleep, or awake in the morning overly tired? Yes:_____ No:_____

Do you experiences headaches Yes: _____ No: _____ If Yes, how often? _____

Do you use tobacco? Yes: _____ No: _____ If Yes, for how long? _____

Notes: _____

_____

_____

_____

Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

Health History Form

Any History Of:

Medications:

Allergy Or Adverse Reaction To Dental Anesthetic	Yes: _____ No: _____	_____
Arthritis	Yes: _____ No: _____	_____
Artificial Joints	Yes: _____ No: _____	_____
Asthma	Yes: _____ No: _____	_____
Cancer	Yes: _____ No: _____	_____
Chemical Dependence (Alcohol/ Drug)	Yes: _____ No: _____	_____
Diabetes	Yes: _____ No: _____	_____
Emotional Stress (Depression/ Anxiety)	Yes: _____ No: _____	_____
Epilepsy	Yes: _____ No: _____	_____
Glaucoma	Yes: _____ No: _____	_____
Headaches	Yes: _____ No: _____	_____
Heart or Valve Problems	Yes: _____ No: _____	_____
Heart Murmur	Yes: _____ No: _____	_____
Hepatitis	Yes: _____ No: _____	_____
High Blood Pressure	Yes: _____ No: _____	_____
HIV + or AIDS	Yes: _____ No: _____	_____
Kidney, Liver or Bladder Disease	Yes: _____ No: _____	_____
Pregnant Currently	Yes: _____ No: _____	_____
Prolonged Bleeding	Yes: _____ No: _____	_____
Rheumatic Fever	Yes: _____ No: _____	_____
Sinus Trouble/Hay Fever	Yes: _____ No: _____	_____
Sleep Apnea (Chronic unrestful sleep)	Yes: _____ No: _____	_____
Smoking/Tobacco Use	Yes: _____ No: _____	_____
Stroke	Yes: _____ No: _____	_____
Thyroid Disease	Yes: _____ No: _____	_____
Tuberculosis	Yes: _____ No: _____	_____

Notes _____

_____

Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

We are honored to aid you on your journey to full health and freedom from addiction. Trust us to be a part of your recovery. It means a lot to us that you allow us to earn your trust. We are committed to being there for you each step of the way. You deserve optimal dentistry and care.

During Active In-Patient Treatment, Out-Patient Treatment or Sober-Living, we are available to address any immediate concerns. We will prioritize your concerns and ensure we will specifically address your needs. We are knowledgeable about how complex this point of life can be, and we will work diligently to make this process as pain-free and simple as possible.

Once stable in recovery, a goal oriented, future-minded approach may be considered for your dental health. We would like to co-create a plan to ensure long term comfort, appearance, and overall oral health.

Commonly, rehabilitation occurs with a team of addiction specialists. We are well versed in communicating our patient's dental needs with medical and dental specialists. It would be our pleasure to participate as a part of your treatment team.

We take our patients privacy seriously. We treat one patient at a time, providing individualized care and attention. We strictly adhere to HIPAA, the law protecting privacy of personal health information. We will only communicate information on our patient's behalf to those we have been granted permission to inform.

Please help us to best understand your current stage of recovery:

□ Active In-Patient Treatment □ Active Out-Patient Treatment
□ Sober Living (sober residence) □ Sober Living (own)

Current Length of Sobriety: _____

Substance(s) being treated for:

□ Alcohol □ Drugs: (please list) _____

If being treated for these, please specifically indicate:

□ Pain medication (Oxycontin, Percocet etc)

□ Benzodiazepines / Anti-anxiety medication (Ativan, Xanax, Valium, etc)

Medications being used in treating/managing addiction or for anti-craving: (please list)

_____

Any specific concerns related to dentistry and your recovery?

_____

_____

_____

_____

Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

**Our office is dedicated to the concept that all people should have the right to retain their natural teeth for a lifetime. Preventative measures, high quality care, and good cooperation combined with timely treatment make it possible for most people to retain their natural teeth with optimum comfort, function, and appearance. My staff and I are dedicated to this concept and with your cooperation we will do everything we can to help you reach your goals for dental health.*

Circle One:

1. My…
   A) mouth is very comfortable.
   B) mouth is moderately comfortable.
   C) mouth is uncomfortable.

2. I…
   A) think the appearance of my mouth is excellent.
   B) am satisfied with the appearance of my mouth.
   C) am dissatisfied with the appearance of my mouth.

3. I…
   A) will do anything to keep my natural teeth.
   B) want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them.
   C) don't care whether I keep them or not.

4. I…
   A) have set goals for my oral health with a previous dentist.
   B) want to set goals concerning my oral health.
   C) have never set goals for my oral health.

5. I…
   A) have always done the best that was recommended for my dental health.
   B) have not done what dentists recommended for my mouth.
   C) rarely go, and don't care much about having any dental work completed.

6. I have…
   A) put dentistry for myself and my family high on my priority list.
   B) put dentistry for myself and my family low on my priority list.
   C) dentistry on my list but is hard to find.

7. I think my present state of dental health is:
   A) Excellent
   B) Good
   C) Poor

8. I aspire to a mouth with:
   A) Excellent Health
   B) Good Health
   C) Poor Health

9. What are some questions about dentistry and oral health that you have never had adequately answered?

   _____

   _____

10.	Are your teeth as white and bright as you would like them to be?	YES	NO
11.	When you look at your teeth, do you see too much gray or black in the back of your mouth?	YES	NO
12.	Are your teeth as straight as you would like them to be?	YES	NO
13.	Do you like the way your teeth are shaped?	YES	NO
14.	Do you like the way your gums look?	YES	NO
15.	Lightening, brightening, straightening, and re-contouring are easy procedures. Are you interested in knowing about them?	YES	NO

Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices for _____, but acknowledgement could not be obtained because:

- **Individual refused to sign**
- **Communications barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (Please Specify)**

Jamie J. Alexander, D.D.S., PA
Cosmetic, Implant and General Dentistry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET 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 takes effect 04/11/03 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, or for additional copies of this notice, please contact us using the information listed 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 and disclose your health information to obtain payment for services we provide to you.**

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 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 written authorizations 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 expect 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 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 you 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.**

National Security: **We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We must disclose to authorize 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, e-mail 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 at the end of this Notice. If you request copies, we will charge you 0.25 for each page, $10.00 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 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 we or 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 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 Transfer: **If you receive this Notice on our Web site or by electronic mail (e-mail), 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 any 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 also may 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 Hyman Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.