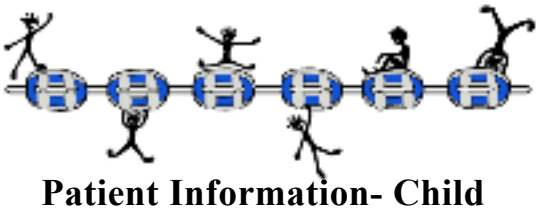
7652 Schomburg Road

Columbus GA, 31909

Jeffrey M. Serff, DMD, PC
Specialist in Orthodontics



O 706-507-0999
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www.serfforthodontics.com

Patient Information- Child

Date _____

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

Patient's Last Name _____ First _____ Middle _____

Patient's Home Address _____

City _____ State_____ Zip Code _____

Preferred name _____ DOB _____ Age _____ Sex : M F

School _____ Grade _____ Patient's Cell #_____

Responsible Party Name _____Relationship to Patient_____

Responsible Party Address _____

City _____ State_____ Zip Code _____ SSN_____

Cell Phone # _____ Home Phone # _____ Email Address _____

Responsible Party is (circle one) Single Married Separated Divorced Widowed

Father's Name _____

Employed By _____ Work Phone # _____

Business Address _____ Occupation _____

City _____ State _____Cell Phone # _____

Mother's Name _____

Employed By _____ Work Phone # _____

Business Address _____Occupation _____

City_____ State _____Cell Phone # _____

In case we can't reach you, person to contact: _____

Relation to patient_____ Phone # _____

Do you have dental insurance that covers orthodontic treatment? Yes_____ No _____ If yes, a copy of your insurance card is required. Insurance may be filed from this office electronically, by mail or by fax.

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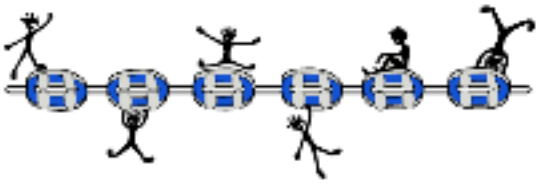

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Health History

Please circle "yes" or "no" beside any medical/dental conditions you may have:

yes no Birth defects or hereditary problems?
yes no Bone fractures or any major accidents?
yes no Rheumatoid or arthritic conditions?
yes no Endocrine or thyroid problems?
yes no Kidney problems?
yes no Diabetes?
yes no Cancer or been treated for a cancer?
yes no Stomach or hyperacidity?
yes no Polio, mono, tuberculosis or pneumonia?
yes no Are your immunizations up to date?
yes no Problems of the immune system?
yes no AIDS or HIV positive?
yes no Hepatitis, jaundice or liver problems?
yes no Fainting spell, seizures, epilepsy or neurologic problems?
yes no Mental health or behavioral problems?
yes no Vision, hearing, tasting or speech difficulties?
yes no Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
yes no High or low blood pressure?
yes no Cardiovascular problem? (murmur, heart trouble, repaired heart valve, stroke, inborn heart defects or rheumatic heart)?
yes no Skin disorder?
yes no Eye, ear, nose or throat condition?
yes no Tonsil or adenoid conditions?
yes no Other physical problems or symptoms?_____

Female Patient:
yes no Are you or might you be pregnant?
yes no Are you taking birth control pills?

Please list any medications you are currently taking_____
_____
Please list any drugs you are allergic to_____
Do you take antibiotics prior to routine dental care?_____

Physician_____Phone #_____Last Visit_____

Dental History
yes no Permanent or “extra” teeth removed or congenitally missing teeth?
yes no Chipped or otherwise injured baby or permanent teeth?
yes no Teeth sensitive to hot, cold; teeth throb or ache?
yes no Jaw fractures, cysts or mouth infections?
yes no Root canals treated teeth?
yes no Bleeding gums or periodontal disease?
yes no Frequent fever blisters, canker sores or cold sores?
yes no Thumb or finger sucking habit? Until _____.
yes no Mouth breathing or difficulty in breathing?
yes no Clicking or locking jaw?
yes no Pain in jaw or ringing in ears?
yes no Any pain or soreness in the muscles of the face or around the ears?
yes no Difficulty in chewing or jaw opening?
yes no Have you ever been treated for “TMJ” problems (your jaw-joint and facial muscle pain)?
yes no Have you ever had any orthodontic treatment or worn a “retainer”
yes no Have you ever had periodontal (gum) treatment?
yes no Aware or concerned about under or over developing jaw relationship?
yes no Any relative with similar tooth or jaw relationship?
yes no Have you had any serious trouble associated with any previous dental treatment?
yes no Have you ever had a prior orthodontic examination or treatment?

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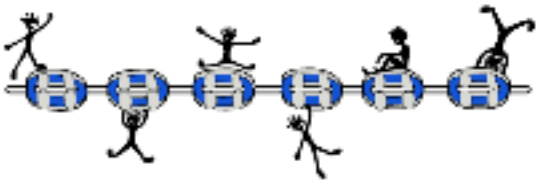

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Name of Patient's Dentist _____

Date of most recent dental examination _____

Additional information/follow-up to questions_____

_____

What is your primary orthodontic concern?

_____

_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene; are there any restrictions , handicaps or problems that might be encountered during treatment?

_____

.

I have read and understand the above questions. I will not hold my orthodontist, or any member of his staff, responsible for any errors or omissions that I have made in the completion of this form.
If there are changes later to this history record or medical/dental status I will so inform this practice.

Signature of Patient/Guardian _____Date_____

NOTICE OF PRIVACY PRACTICES

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.

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit our office, we make a record of your visit in order to manage the care you receive. We understand that the medical information that is recorded about you and your health is personal. The confidentiality and privacy of your health information is also protected under both state and federal law. This Notice of Privacy Practices describes how this office may use and disclose your information and the rights that you have regarding your health information.

How We Will Use or Disclose Your Health Information

Treatment: We will use your health information for treatment. For example, information obtained by the orthodontist or other members of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your orthodontist will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations, so the physician will know how you are responding to treatment. We will also provide your physician, or a subsequent healthcare provider, with copies of various reports that should assist him or her in treating you.

Payment: We will use your health information for payment. For example, a bill may be sent to you or your health plan. The information on or accompanying the bill may include information that identifies you, as well as

your diagnosis, procedures, and supplies used.

Health Care Operations: We will use your health information for our regular health care operations. For example, we may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used in a continued effort to improve the quality and effectiveness of the services we provide.

Business Associates: We may enter into contracts with persons or entities known as business associates that provide services to or perform functions on our behalf. Examples include our accountants, consultants, and attorneys. We may disclose your health information to our business associates so they can perform the job we have asked them to do, once they have agreed in writing to safeguard your information.

Notification: We may use or disclose information to assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided to us, e.g., on an answering machine.

Communication with Family: We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person¸s involvement in your care or payment related to your care.

Appointment Reminders / Health Benefits: We may contact you to provide appointment reminders or information about treatment alternatives or other health benefits that may be of interest to you.

Funeral Directors and Coroners: We may disclose your health information to funeral directors, and to coroners or medical examiners, to carry out their duties consistent with applicable law.

Organ Procurement Organizations: Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Research: We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may also disclose your health information to people preparing to conduct a research project, so long as the health information is not removed from us. We may also use and disclose your health information to contact you about the possibility of enrolling in a research study.

Fundraising: We may contact you as part of our fundraising efforts; however, you may opt-out of receiving such communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers¸ Compensation: We may disclose health information to the extent authorized by and to the extent necessary, to comply with laws relating to workers¸ compensation or other similar programs established by law.

Public Health Activities: As required by law, we may disclose your health information to public health, or legal authorities, charged with preventing or controlling disease, injury, or disability.

Health Oversight Activities: We may disclose your health information to health oversight agencies for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution, or agents thereof, health information necessary for your health and the health and safety of other individuals.

Judicial and Administrative Proceedings: We may disclose your health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.

Law Enforcement Purposes / Serious Threat to Health or Safety: We may disclose your health information to enforcement officials for law enforcement purposes under certain circumstances and subject to certain conditions. We may also disclose your health information to prevent or lessen a serious and imminent threat to a person or the public (when the disclosure is made to someone we believe can prevent or lessen the threat) or to identify or apprehend an escapee or violent criminal.

Victims of Abuse, Neglect, and Domestic Violence: In certain circumstances, we may disclose your health information to appropriate government authorities if there are allegations of abuse, neglect, or domestic violence.

Essential Government Functions: We may disclose your health information for certain essential government functions (e.g., military activity and for national security purposes).
The following uses and disclosures will be made only with your authorization: (i) with limited exceptions, uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in this notice. You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

Your Health Information Rights

Although your health record is the physical property of this office, you have the following rights with respect to your health information:

You may request that we not use or disclose your health information for a particular reason related to treatment, payment, our general healthcare operations, and/or to a particular family member, other relatives or close personal friend. We ask that such requests be made in writing on a form provided by us. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it, except as provided below.

If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We ask that such requests be made in writing on a form

provided by us. We are required to abide by such a request, except where we are required by law to make a disclosure. We are not required to inform other providers of such a request, so you should notify any other providers regarding such a request.

You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing, and submitted to the Privacy Officer. We will attempt to accommodate all reasonable requests.

You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If we maintain your health information electronically in a designated record set, you may obtain an electronic copy of the information. If you request a copy (paper or electronic), we will charge you a reasonable, cost-based fee.

If you believe that any health information in your record is incorrect, or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by us to make such requests. For a request form, please contact the Privacy Officer.

You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed six years), as required by law. We ask that such requests be made in writing on a form provided by us. Please note that accounting does not include all disclosures, e.g., disclosures to carry out treatment, payment, or healthcare operations and disclosures made to you or your legal representative or pursuant to an authorization. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee.

You have the right to be notified following a breach of your unsecured protected health information. You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I,_____, have read or received a copy of this Office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

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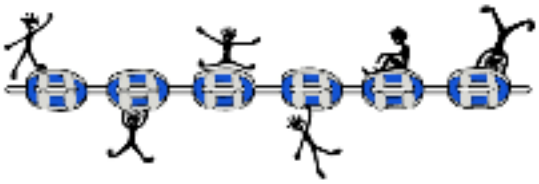

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Welcome

Welcome to our practice! We would like to thank you for choosing us to provide your orthodontic care. For your information and to better serve you, we have prepared this information sheet outlining our office policies regarding treatment fees and orthodontic insurance.

Treatment fees and Payment

We make every effort to accommodate and inform our patients regarding treatment fees. At the start of treatment, the financial agreement is signed and explained to the responsible party. A payment option is chosen and orthodontic insurance, if any, is filed.

Payments are expected before or on the due day set in the financial agreement. We understand that complications do arise and special situations may occur. In the event you need to change your financial arrangements, please call us immediately to prevent complications. The fees we charge for services rendered to those who are insured are our usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule, which may or may not coincide with our usual fees. There is no direct relationship between this office and your insurance company. All fees are arranged with and are the responsibility of the individual patient or family. Please feel free to contact our office if you have any questions. We will be happy to assist you.

Orthodontic Insurance

We file orthodontic insurance as a courtesy and convenience to our patients. Insurance claims may be filed by mail, fax or electronically. We do not charge any additional fees to provide this service. We would like to clearly identify the relationship between the three of us: your insurance company, you, and this office. The relationship between you and this office is that you have contracted with us to provide orthodontic services. There is no direct relationship between your insurance company and this office. Your insurance company has to answer to you and your employer, not this office.

There is no way to know exactly what your insurance will or will not pay. We attempt to estimate your coverage to the best of our knowledge. Insurance companies will give us a general description of benefits, but this is no guarantee of payment. We are happy to file a pre-treatment estimate before treatment is started, but again this is not a guarantee of payment. Many factors can and do change the amount of insurance benefits paid.

Any and all fees unpaid by the estimated insurance benefits will be due from the patient/responsible party. We file all claims in good faith that the benefits described by you and your insurance company will be paid in a timely manner. If there is a dispute between what your insurance company will pay and what you feel they should pay, you will have to resolve this with your insurance company. Any disputed unpaid amount will be placed onto the patient's ledger and paid by the patient. You will have to seek reimbursement from the insurance company.

If your coverage or insurance company should change, it is your responsibility to notify this office and provide the correct information. Delays in reporting new information will result in an unnecessary confusion caused by filing to the wrong insurance company. Please make us aware as soon as possible of any changes to your orthodontic insurance.

Thank you again for allowing us to provide your orthodontic care. If ever you have a question or concern, please do not hesitate to ask. We appreciate the opportunity you have given us to serve you.

_____ _____

Signature of Patient or Responsible Party Date

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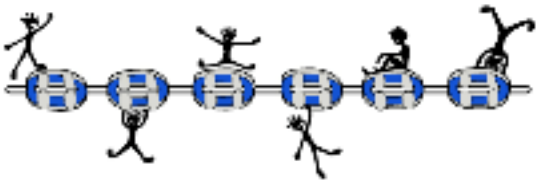

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Insurance Coverage Information/Authorization to File

Patient FULL Name _____
Sex M_____ F_____ Date of Birth _____/_____/_____

PRIMARY Insurance Company_____
Subscriber FULL Name_____
Subscriber SSN_____ Date of Birth_____/_____/_____
Relationship to Patient
____Parent ____Step-Parent_____Spouse_____Self_____ Other, Explain:_____
Employer Name_____

SECONDARY Insurance Company_____
Subscriber FULL Name_____
Subscriber SSN_____ Date of Birth_____/_____/_____
Relationship to Patient
____Parent ____Step-Parent_____Spouse_____Self_____ Other, Explain:_____
Employer Name_____

**IF ANY SUBCRIBER LISTED ABOVE, DOES NOT LIVE WITH OR HAVE THE SAME MAILING ADDRESS AS THE PATIENT, THE INSURANCE COMPANY WILL REQUIRE THE CORRECT MAILING ADDRESS FOR THE SUBSCRIBER TO BE LISTED ON ANY CLAIMS FILED. IF THIS SITUATION APPLIES TO YOU, PLEASE COMPLETE THE FOLLOWING INFORMATION:

CIRCLE ONE PRIMARY OR SECONDARY
Street Address_____
City_____ State_____ Zip Code_____

IF YOU CANNOT PROVIDE THIS INFORMATION, WE WILL BE UNABLE TO FILE YOUR INSURANCE CLAIMS

I hereby authorize release of any information necessary or relating to processing any insurance claim.

Signature of Patient, or Parent if Minor_____Date_____

I hereby authorize payment directly to the provider of the insurance benefits otherwise payable to me.

Signature of Patient, or Parent if Minor_____Date_____