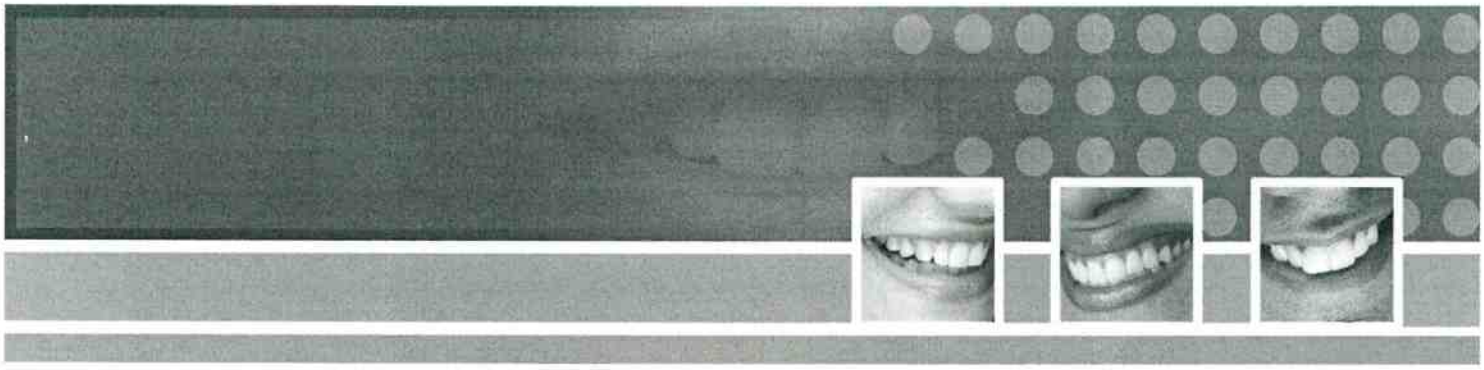


PATIENT INFORMATION

Chart #. _____
FOR OFFICE USE ONLY

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

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Who may we discuss treatment, finances or reference appointments with:

_____

Whom may we thank for referring you to our practice?

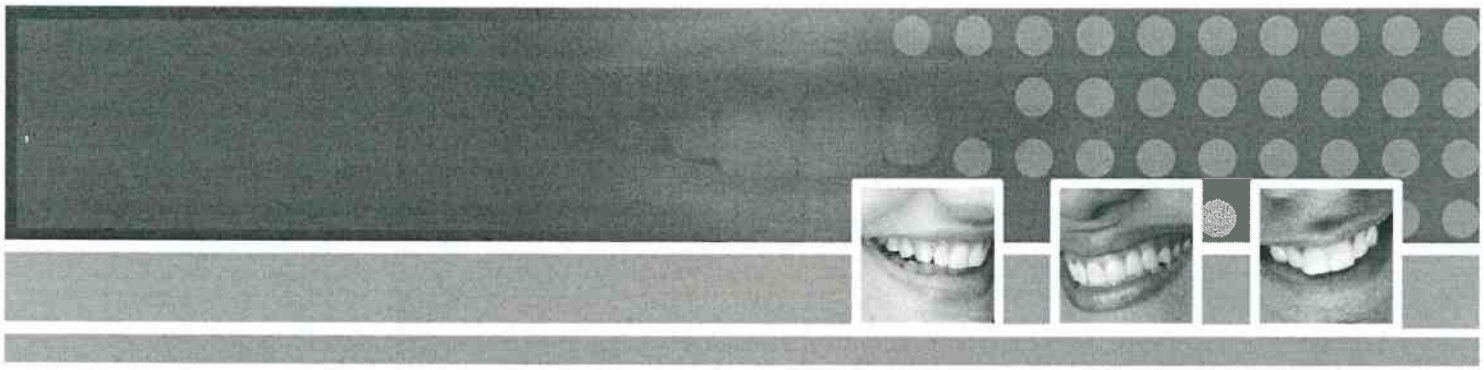
* ☐ Dental Office ☐ Newspaper ☐ Yellow Pages

☐ School ☐ Internet ☐ Work

☐ Other (name below):

Name of person, office, or other source referring your to our practice:

_____



Primary Insurance Information:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

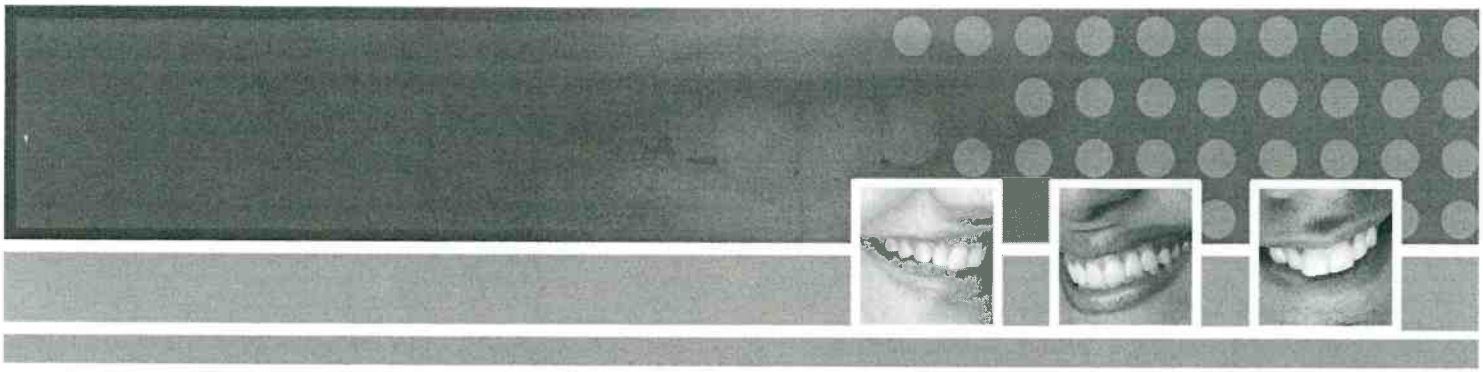
_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)



Secondary Insurance Information:

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

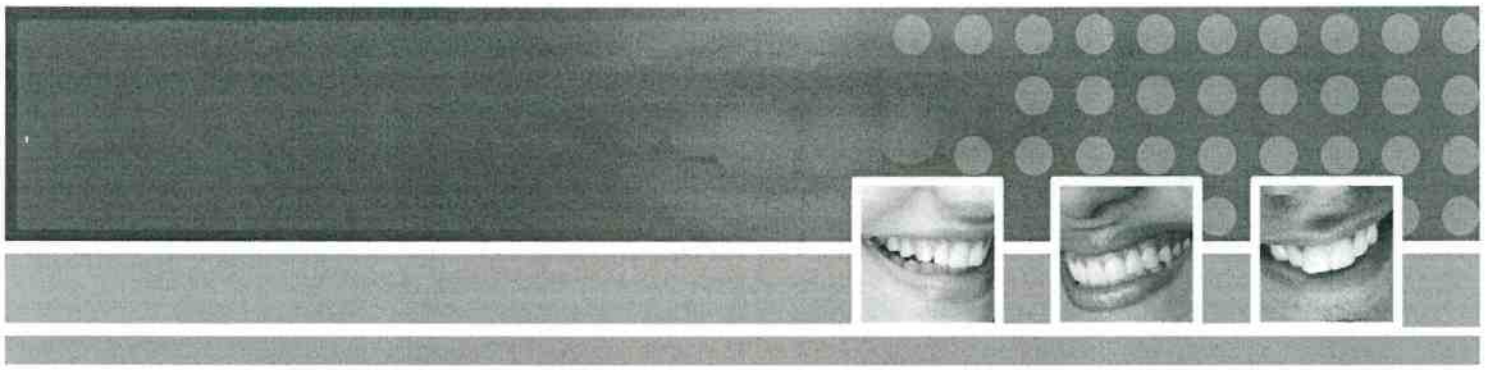
_____ (City) ____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) ____ (State) _____ (Zip Code)



Emergency Contact:

Name:

*

Phone:

*

Name:

Phone:

Insurance Assignment of Benefits Release

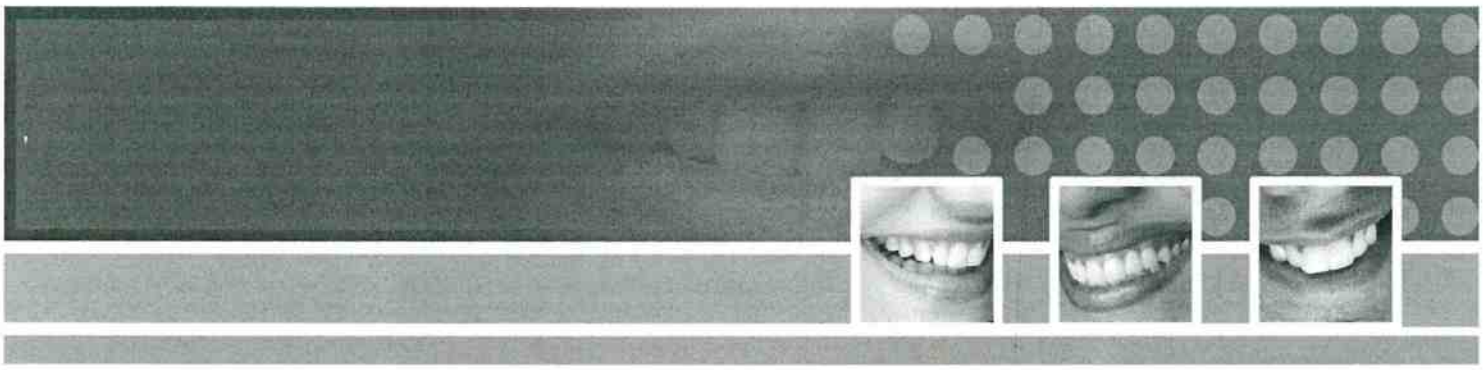
By signing below, I acknowledge all insurance benefits, if any will be paid to Bushnell Family and Cosmetic Dentistry or Sumter Dental Center, PA. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date:

Name of patient, parent or guardian completing this form:

Relationship to patient:

* ☐ Self ☐ Parent ☐ Guardian ☐ Other



Medical History

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

ALLERGIES:

Do you have any known allergies to any drugs, medications, or materials?

* ◯ Yes ◯ No

If you have had any allergic reactions to any of the following, please specify:

- ☐ latex
- ☐ penicillin or amoxicillin
- ☐ acrylic
- ☐ clindamycin
- ☐ metals or jewelry
- ☐ codeine or any synthetic codeine

If you have had any other allergic reaction, please specify:

_____

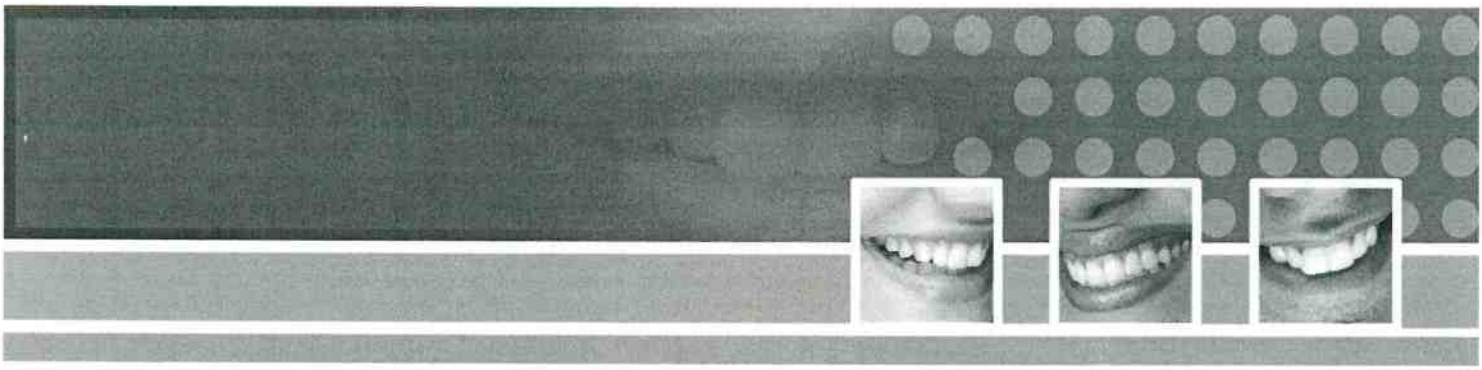
ANTIBIOTIC PROPHYLAXIS (PRE-MEDICATION):

Does you physician require you to take antibiotic prior to dental procedures as protective measure?

* ◯ Yes ◯ No

Please check any of the following that apply:

- ☐ artificial heart valve(s)
- ☐ previous history of infective endocarditis
- ☐ cardiac transplant which developed a heart valve problem
- ☐ cyanotic congenital heart defect that is not fully repaired
- ☐ prosthetic device placed in the heart in the last 6 months
- ☐ total joint replacement within the last 2 years
- ☐ developed an infection following a total joint replacement



BLOOD/CARDIOVASCULAR SYSTEM:

Please check any of the following that apply:

- ☐ pacemaker
- ☐ heart attack within the last 6 months
- ☐ heart surgery or vascular surgery with the last 6 months
- ☐ chest pains (angina)
- ☐ high blood pressure
- ☐ high blood pressure that is NOT well controlled
- ☐ bruise easily or bleed excessively
- ☐ stroke or mini-stroke
- ☐ anemia

Please provide details for any of the above responses:

DIABETES:

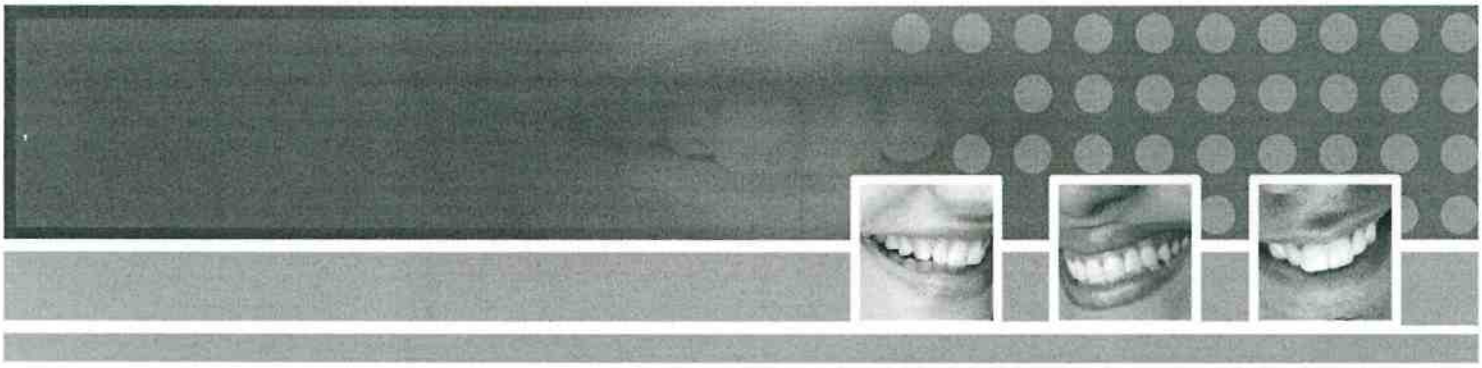
Please check any of the following that apply:

- ◯ no history of diabetes
- ◯ diabetes that is well controlled
- ◯ diabetes that is NOT well controlled

DIGESTIVE SYSTEM

Please check any of the following that apply:

- ☐ stomach ulcers
- ☐ inflammatory bowel disease
- ☐ ulcerative colitis
- ☐ Crohn's disease



RESPIRATORY SYSTEM:

Please check any of the following that apply:

☐ asthma ☐ asthma attacks ☐ emphysema ☐ COPD

☐ bronchitis

Do you have any history or have you ever tested positive of tuberculosis

* ◯ Yes ◯ No

If so, please provide details:

RENAL SYSTEM/ KIDNEYS:

Please check any of the following that apply:

☐ history of kidney disease ☐ dialysis ☐ shunt

Please provide details for any of the above responses:

IMMUNE SYSTEM:

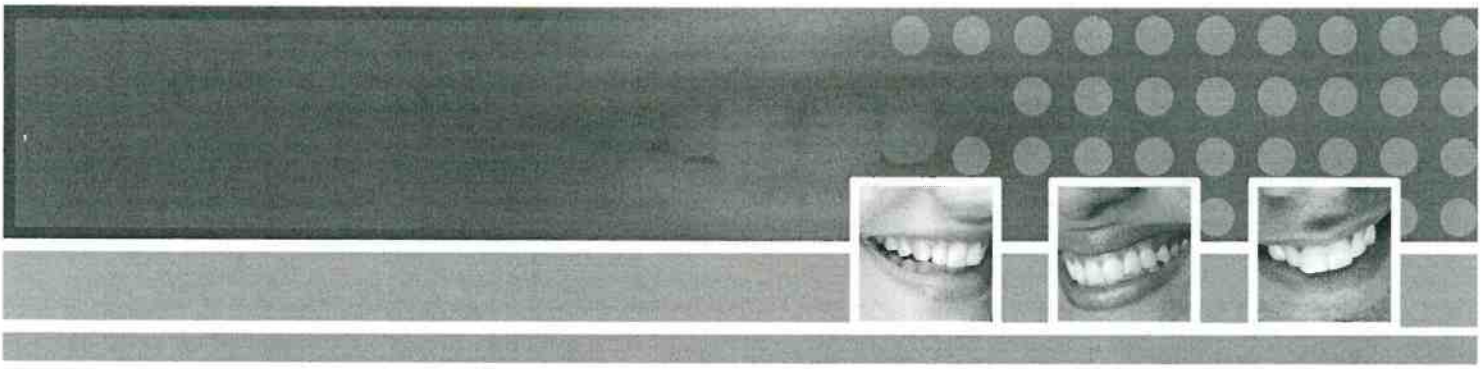
Is your immune system affected by any disease, or medical procedure(s)?

* ◯ Yes ◯ No

If so, please provide details:

Do you have any history of HIV/AIDS?

* ◯ Yes ◯ No



HEPATIC SYSTEM/LIVER:

Please check any of the following that apply:

☐ history of liver disease ☐ hepatitis ☐ jaundice

☐ cirrhosis of the liver

Please provide details for any of the above responses:

CANCER:

Please check any of the following that apply:

☐ history of cancer

☐ previous cancer treatment

☐ current cancer treatment

☐ planned future cancer treatment

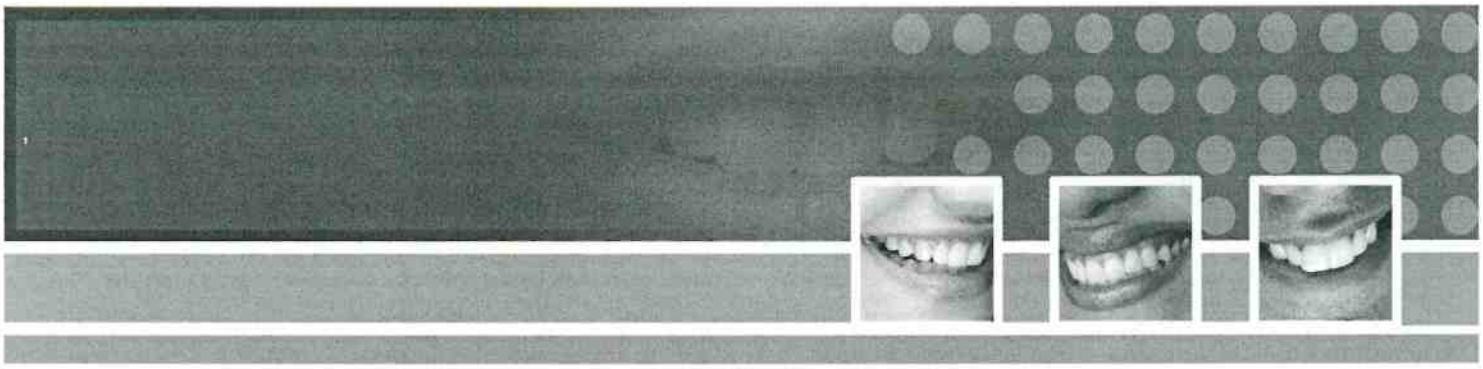
☐ previous radiation therapy of the head or neck region

Please provide details for any of the above responses:

Do you have any history of epilepsy or seizures?

◯ Yes ◯ No

If so, please provide details:



ANESTHESIA:

Have you or any immediate family member had problems with IV anesthesia?

◯ Yes ◯ No

Have you ever had any complications from local dental anesthetic (including topical anesthetics)?

* ◯ Yes ◯ No

TEMPOROMANDIBULAR JOINTS (JAW JOINTS):

Please check any of the following that apply:

☐ clicking or popping of the jaw joint
☐ limited opening of the jaws
☐ history of waring a bite splint or nightguard
☐ pain in the jaw joint region
☐ clinching or grinding of the teeth

Please provide details of any "yes" responses:

OTHER:

Please check any of the following that apply:

☐ glaucoma ☐ mental disorders ☐ nervous disorders ☐ HPV

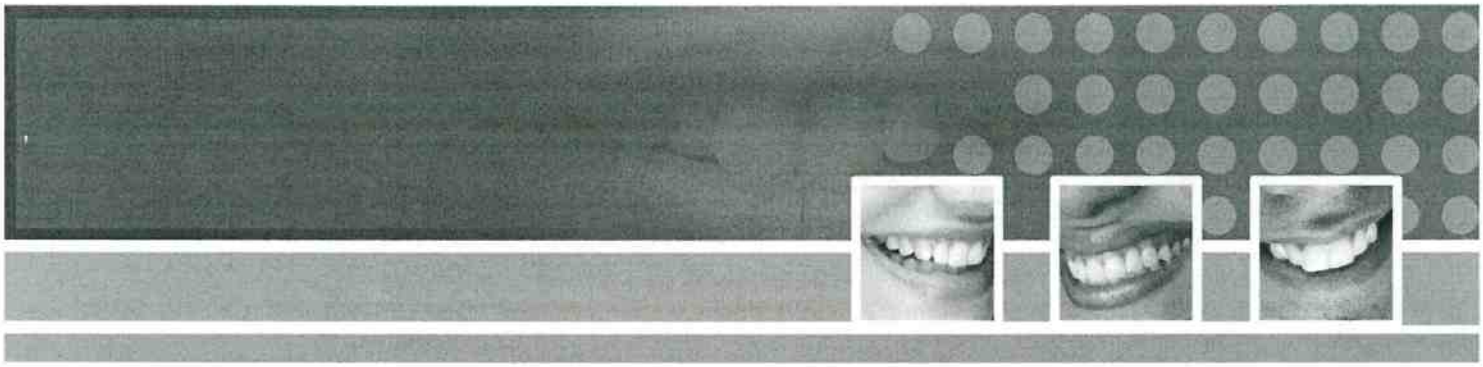
FEMALE PATIENTS ONLY (male patients proceed to medication section):

Are you pregnant or is there any chance that you might be pregnant?

◯ Yes ◯ No

Please check any of the following that apply:

☐ pregnant less than 3 months ☐ pregnant 3-6 months ☐ pregnant 6-9 months
☐ nursing ☐ taking birth control pills



MEDICATIONS:

Are you taking any medications which thin your blood or make you bleed more easily?

◯ Yes ◯ No

Have you EVER taken any medications for osteoporosis or bone cancer?

◯ Yes ◯ No

If yes, please list the medication, duration, method it was administered (pill, IV, intramuscular).

Have you ever taken medications for osteoporosis or bone cancer that were administered intravenously (IV)?

◯ Yes ◯ No

Are you currently taking any medications?

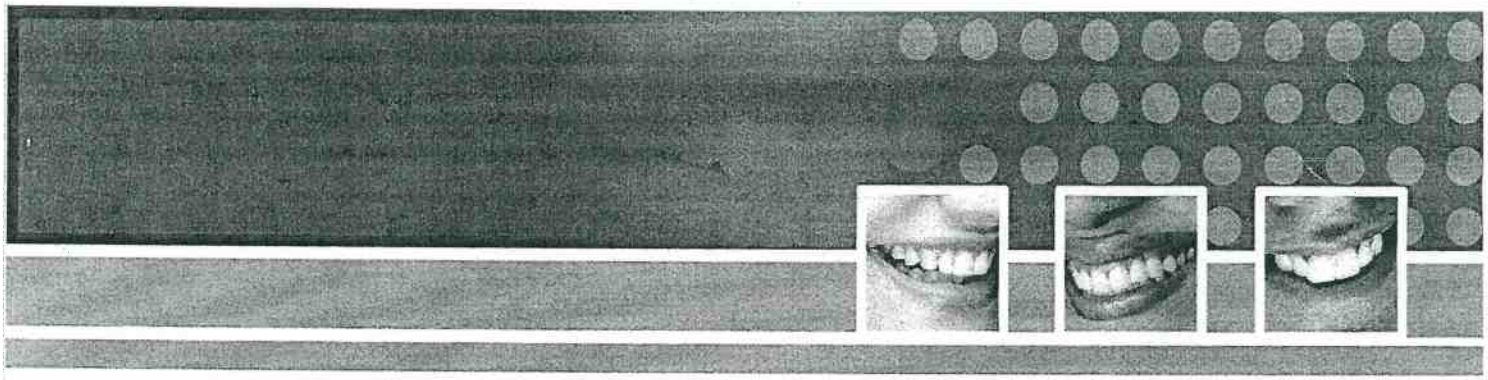
◯ Yes ◯ No

Please list any medications that you are currently taking and the reason(s) why:

I understand the importance of the truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

Signature: _____ Date:

Response Date:



Bushnell Family & Cosmetic Dentistry and Sumter Value Dental
Financial Policy

In order to best serve all of our patients, we require that all patients adhere to our Financial Policy as a stated herein. Please read this policy carefully and ask any of our team members if you have any questions or desire any additional information. Thank you!

Payment Options:

Payment is due when service are rendered unless other arrangements have been made at least three full working days in advance of your appointment. In most cases, your payment for the day's services will be collected PRIOR to seeing the provider on the date of service.

The following forms of payment are accepted:
Cash
Personal Checks*
Money Orders
Debit Cards
Most Major Credit Cards
Lending Club/Springstone, CareCredit Financing Plans.

*We do not accept personal checks in excess of $300.00 unless the check payment is made far enough in advanced as to allow the check to clear the bank prior to the treatment being performed OR your have an excellent, long-term payment history with our practice.

Returned Check Policy:

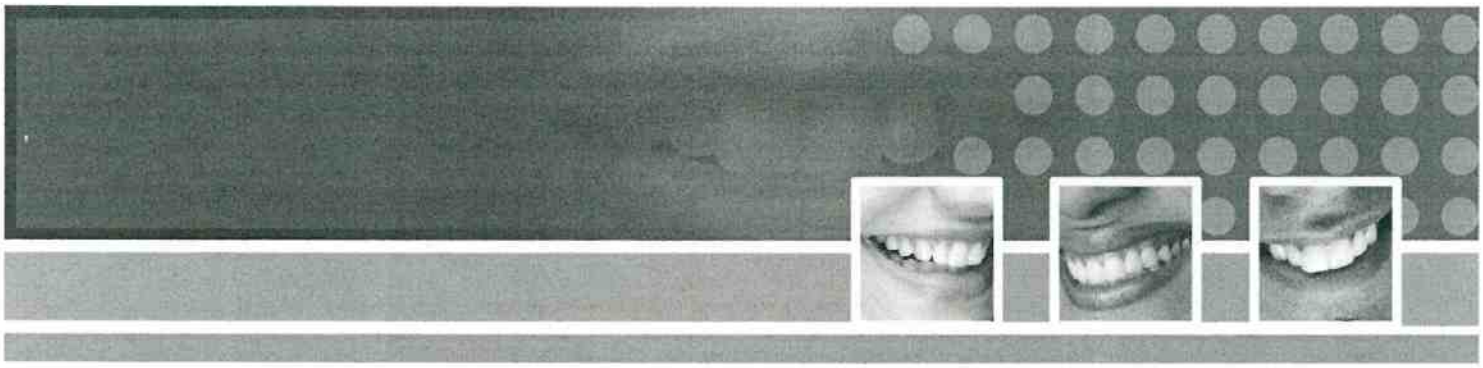
The maximum fees allowed by law at the time the check is written will be applied to all returned dishonored check. You will be sent a letter notifying you of the (dishonored) checks. You will have 15 days to make full payment of the face value amount and the applicable fee. If full payment is not received in the allotted time, the State Attorney's Office will be contacted for criminal prosecution. Full payment of the original check amount plus any fees must be either in cash or by money order.

Monthly Statements:

If you have a balance on your account of $5.00 or more, we will send you a monthly statement. please note that to minimize operation costs, no statements will be mailed for balances less than $5.00. The monthly statement will show separately any previous balance, any new charges, any finance charges and any payments or credits applied to your account during the billing cycle. Unless otherwise approved by us in writing, the entire balance on your statement is due and payable when the statement is issued. THIS AMOUNT IS CONSIDERED PAST DUE IF NOT PAID WITHIN 30 DAYS OF THE STATEMENT DATE.

Past Due Accounts:

A re-billing fee of $3.00 will be imposed on each account that is over thirty (30) days past-due. We will determine your account past-due by taking the balanced owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.



A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of (1.5% per month or an ANNUAL PERCENTAGE RATE of eighteen percent (18%). The finance charge on you account is computed at the rate of (1.5%) to the overdue balance on your account. the overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $0.50.

We reserve the right to report your account status to any credit reporting agency (such as a credit bureau) should your account not be paid within 60 days of the original statement date (or the minimum time required by law, whichever is greater).

If your account becomes past due, we will take necessary steps to collect this debt. we reserve the right to collect re-billing fees (late fees), finance charges (interest), collections agency fees, court costs, reasonable attorney fees, and all other such costs on any outstanding past due balance whether or not a suit is filed. you agree to pay all such costs that are associated with collection you past due balance. In the even of suit, you agree that the venue shall be in Sumter County, Florida.

Waiver of Confidentiality:

You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce:

In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent/guardian authorizing treatment for a child will be the parent/guardian responsible for those charges. If the divorce decree requires the other parent/guardian to pay all or part of the treatment costs, it is the authorizing parent's/guardian's responsibility to collect from the other parent/guardian.

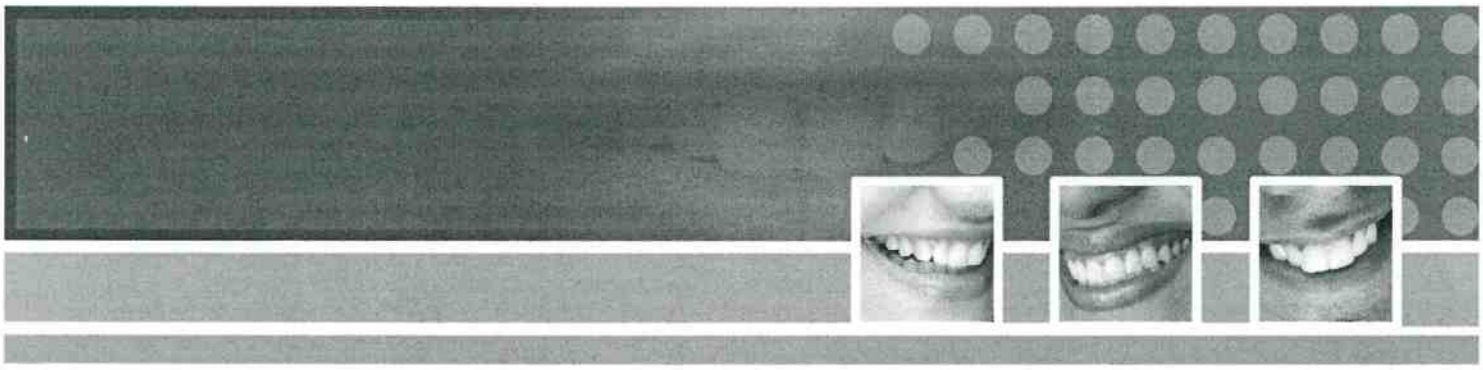
Personal Injury Cases:

If you are being treated as part of a personal injury lawsuit or claim, we require verification from you attorney PRIOR to you initial visit. Payment of all associated fees is responsibility of the patient, unless other arrangements are made in advance. we will not bill you attorney for the charges incurred due to a personal injury case.

Effective Date:

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

This is an agreement between Joseph Brent Novak DMD, PA (d/b/a Bushnell Family and Cosmetic Dentistry and Sumter Value Dental), a Florida Professional Association, as creditor, and the Patient/Debtor named on this form. In this agreement, the words "you", "your" and "yours" mean the Patient/Debtor. The charges are made and payments credited. The words "we", "us", and "our" refer to Bushnell Family & Cosmetic Dentistry and/or Sumter Value Dental. By executing this agreement, you are agreeing to pay for all services that are received.



Dental Insurance:

A dental insurance company is a business which makes a profit by taking more money in premiums than it pays out in benefits. Dental Insurance Benefits should be viewed as just that....benefits. There is never any guarantee of payment. Please not that a dental insurance company can demand that benefits be repaid to them years after they were paid out (even if the payment was the result of an error on their behalf) and leave you responsible for any subsequent balances.

As a courtesy to you, we will provide you with an estimate of the amount of dental insurance benefits associated with the given procedures. These are merely estimates as we have no way of actually knowing how much, if anything, your particular insurance company will pay. You should never make your treatment decisions based on anticipated insurance benefit payments. Your treatment decisions should be made based on your dental needs and your personal desires.

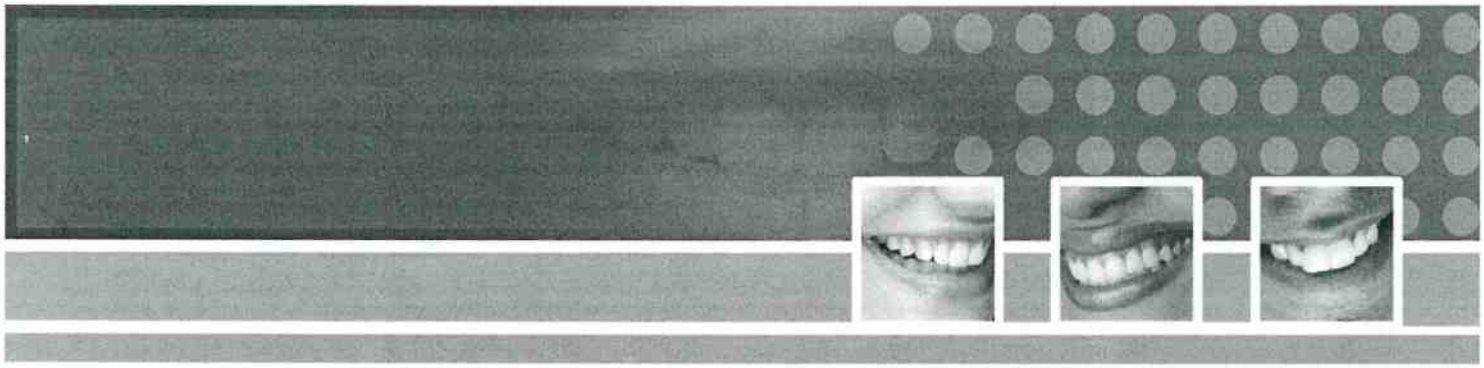
If your insurance coverage cannot be verified at the time of your appointment, you will be asked to pay the full about at the time of service. You can then have any insurance benefits payment associated with the visit mailed directly to you. It is your responsibility to notify our office immediately of any changes in your dental insurance coverage.

It is the insurance company, not us, that makes the final determination of your eligibility of benefits. It is your responsibility to be familiar with the provisions/limitations of your insurance coverage.

CONTRACTED INSURANCE: If we are contracted with your insurance company, we MUST follow our contract and its requirements. We are required to collect all co-payments and/or deductibles in full at the time of service. It is your responsibility to verify THROUGH YOUR INSURANCE CARRIER that our office is a participating provider for your particular insurance plan.

Many insurance contracts state that our standard fees (not the lower contracted fees) are to be charged for non-covered procedures. This contract provision can result in a much higher out-of-pocket costs for you should the insurance company determine that a procedure is not covered.

NON-CONTRACTED INSURANCE: In this case, there is only a contract between you (and/or your employer) and your insurance carrier. We are NOT a party to this contract. As a courtesy to you, we will file claims with your insurance company to get you reimbursement in the amount the insurance company would normally cover for that treatment. Any reimbursement from your insurance company will be sent directly to you. you will be responsible for the payment in full to our office before or on the day of treatment in accordance with this financial policy.



Financially Responsible Party Information and Signature:

PLEASE NOTE ONLY ONE PERSON CAN BE FINANCIALLY RESPONSIBLE PER FAMILY.

The following information is to be completed by the person financially responsible for this patient's account. The person financially responsible must be over the age of 18. All items marked with an asterisks require a response.

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

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile)

Best time to call: _____

Date of Birth:

* _____

Social Security Number:

* _____

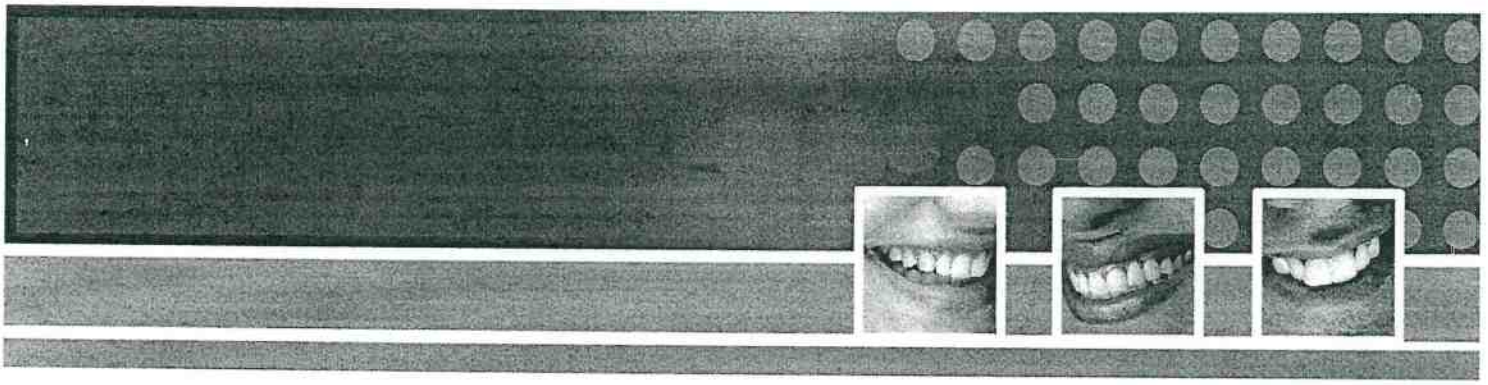
Please list below any individual that you are financially responsible for:

_____

By signing below, you are accepting financial responsibility for this patient's account. Furthermore, you are agreeing to all of the terms and conditions contained herein and this agreement will be in full force and effect.

Signature: _____ Date: _____

Response Date: _____



Bushnell Family & Cosmetic Dentistry
and
Sumter Value Dental

Acknowledgement of Receipt of Notice of Privacy Practices

You may Refuse to Sign This Acknowledgment

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

I have received a copy of Bushnell Family & Cosmetic Dentistry's and Sumter Value Dental's Notice of Privacy Practices.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, 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)

Response Date: _____