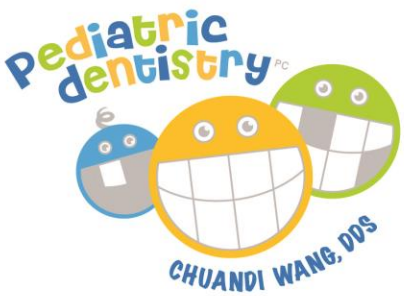

PATIENT REGISTRATION

Patient's Name: M/ F Birth date: SS#:

Patient's Address: Home Phone:

City: State: Zip Code: Cell Phone:

Who has Custody of Patient? Do you have Healthy Kids/MIChild Insurance? Yes/No ID#

Father/Guardian: Birth date: SS#:

Marital Status: Relationship to Patient: Email:

Address: City: State: Zip:

Cell Phone: Home Phone: Work Phone:

Father/Guardian Employer: Address: City: State:

Dental Insurance: Group# ID#

Do you authorize payment directly to dentist? Yes No Signature:

Mother/Guardian: Birth date: SS#:

Marital Status: Relationship to Patient: Email:

Address: City: State: Zip:

Cell Phone: Home Phone: Work Phone:

Mother/Guardian Employer: Address: City: State:

Dental Insurance: Group# ID#

Do you authorize payment directly to dentist? Yes No Signature:

Family's Emergency contact Name: Phone#:

Friend's Emergency contact Name: Phone#:

AS A COURTESY, WE WILL BILL YOUR INSURANCE FOR YOU. ANY REMAINING BALANCE WILL BE YOUR RESPONSIBILITY.

Signature: Date:

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Pediatric dentistry PC

CHUANDI WANG, DDS

PATIENT HEALTH HISTORY

Name:_____ **D.O.B:**_____**Age:**_____ **Sex: M/F**

	Information Requested	YES	NO	Explanation
1	Does your child have a specific medical condition?			
2	Current drugs or medications?			
3	Allergies to medications or latex?			
4	Pregnant? (for adolescent)			
5	Liver disease, hepatitis or jaundice?			
6	Heart disease or murmur?			
7	History of Rheumatic fever?			
8	Respiratory or breathing problems or asthma?			
9	Frequent colds, sore throat or sinus problems?			
10	Blood disease or bleeding disorder?			
11	Radiation therapy or chemotherapy?			
12	Convulsions or seizure disorder?			
13	Nervous system problem?			
14	History of psychiatric/psychological counseling?			
15	Endocrine disease (thyroid, diabetes)?			
16	Stomach or intestinal problems?			
17	Kidney or bladder problems?			
18	Has your child ever been hospitalized?			
19	Has your child ever had surgery?			
20	History of reaction to anesthesia or sedation?			
21	Are immunizations up to date?			
22	Learning disability or developmental delay?			
23	Skin, bone or hair problems?			
24	Autism spectrum, ADHD, behavior problems?			
25	Other comments?			
		YES	**NO**	**Explanation**
26	Is this your child's first dental visit?			If no, date of last dental visit?
27	Are there any previous unhappy dental experiences?			
28	Is your child a patient at any other dental office?			
29	Is your child exposed to fluoride in any form?			
30	Does your child have any oral habits? (Thumb sucking, nail biting, sleeping with bottle, pacifier, etc.)			

The questions have been accurately answered to the best of my knowledge. I understand that incorrect information may be dangerous to my child's health. It is my responsibility to inform the dental office of any health changes.

Parent/Guardian Signature:_____ **Date:**_____.
Reviewed by:_____ **Date:**_____.

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Pediatric dentistry PC

CHUANDI WANG, DDS

MEDICATION REGISTER

List all medications your child is currently taking

Today's Date	Medication	Dosage/Schedule	Reason for medication	Prescribed By

Reviewed by: _____Date: _____

PHYSICIAN REGISTRY

Physician: _____Specialty: _____

Address: _____

Telephone: _____Date Last Seen: _____

Physician: _____Specialty: _____

Address: _____

Telephone: _____Date Last Seen: _____

Physician: _____Specialty: _____

Address: _____

Telephone: _____Date Last Seen: _____

Physician: _____Specialty: _____

Address: _____

Telephone: _____Date Last Seen: _____

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Written Financial Policy

Thank you for choosing Chuandi Wang, DDS, Pediatric Dentistry, PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, Discover Card and American Express
- NO INTEREST[1] Payment Plans[2] from CareCredit
    - Allow you to pay over time with NO INTEREST[1]
    - Convenient, low monthly payment plans[2] also available
    - No annual fees or pre-payment penalties

Please note:

We require payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring more than 2 appointments, alternative payment arrangements may be provided.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

There will be a $25 charge for returned checks.

If you have any questions, please do not hesitate to ask. We look forward to working with you.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier

TEMPORARY GUARDIANSHIP AGREEMENT

In case parent/guardian does not bring patient, **it is required by state law,** that we have a signed consent form in all our patient's charts. We **will not** be able to give dental care, unless we have this form. If we are doing major dental care or sedation, a parent/guardian **must** accompany patient to appointment and stay in office until patient is released. We are also asking parent/guardian to give a list of people who are able to make decisions on your behalf regarding basic dental treatment.

I consent to having dental treatment done on patient(s) listed below without my presence.

List patient(s) (Print)

_____.
_____.
_____.
_____.
_____.
_____.

List of name(s) who can bring above named patient(s) to have basic dental care done.

Name:_____ Relationship to patient(s):_____.

Name:_____ Relationship to patient(s):_____.

Name:_____ Relationship to patient(s):_____.

This shall be in effect from _____ until revoked.

Parent/guardian signature Date

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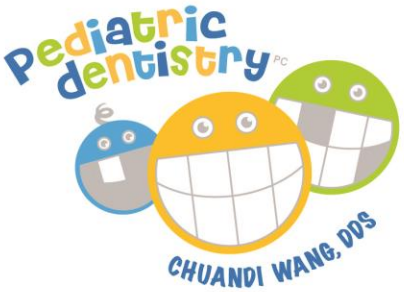


Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA requires us to disclose regarding our privacy practice. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

List Patient Names (Print)

_____. _____.

Parent/Guardian Signature _____.

_____.

_____.

Date:_____.

For office use only Patient refused to sign The following circumstances prohibited the patient from signing the Acknowledgement:
An emergency situation prevented the patient from signing the Acknowledgement. _____. Office Personnel (signature) Office Personnel (Print name) Date:_____.

Patient Consent

Please sign this form below under the heading "consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

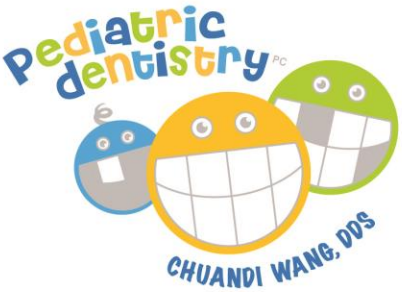
List Patient(s) Name (print)

_____. _____.

Parent/Guardian Signature _____.

_____.

Date:_____. _____.



CANCELLATION AND NO-SHOW POLICY

Quality care for our patients is our priority. Please take a few minutes to review our cancellation and no-show policy and sign at the bottom of the form. If you have any questions please let us know.

Definition of a "Same day cancellation" or "No-Show" Appointment. Dr. Chuandi Wang, Pediatric Dentistry, PC. defines as any scheduled appointment in which the patient either:
-Does not show
-Cancels with less than 24 hours notice
-Arrives more than 30 minutes late and is consequently unable to be seen

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients.

When a patient "no-shows" for a scheduled appointment it:
-Potentially jeopardizes the health of the "no-showing" patient
-Is unfair (and frustrating) to other patients that would have happily taken the appointment slot
-Disrespects not only the provider's time, but also the time of the entire clinic staff

Our office will attempt to contact you two business days before your scheduled appointment to confirm your visit. If we are unable to speak with you, a message will be left for you.

When scheduling an office visit with us, **please arrive 5-10 minutes prior to your scheduled visit**. This allows time for you and our staff to address any insurance or billing questions and/or to complete any necessary paperwork before the scheduled visit.

When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to redirect your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient.

Consequences of "Same day Cancellation" or "No-Show" appointments:
-A charge of $25 may be assessed to your account
-If three appointments within a six month period are missed, your child will be subject to dismissal from our office and only emergency dental treatment will be offered for up to 30 days while you find another office. Any remaining scheduled appointments will be cancelled.

I have read and understood the "Same day cancellation" and "No Show" Policy as described above.

Patient Name: _____

Parent/Guardian Signature: _____Date:_____

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