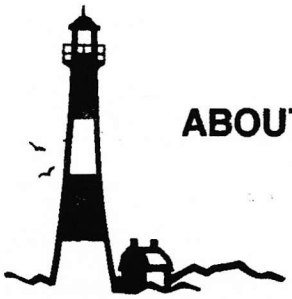


ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

DR. MARK J. HARRIS, DMD
Family Dentistry

We are committed to providing you with the best possible care. If you have dental or medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard or Visa. We will be happy to help you process your insurance claim-form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances we may accept assignment of insurance benefits.

We may accept your insurance if you obtain approval from our staff prior to the date of service. If we accept your insurance, you must pay at least 30% of total charges at time of service (some procedures require 50% payment). If your insurance company has not paid the FULL BALANCE within 45 days, you have 15 days to pay the balance. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1½% per month. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of "U.C.R.". "U.R.C." is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.

   This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

PATIENT'S NAME _____

❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ WIDOWED ❑ DIVORCED

DATE OF BIRTH _____ AGE _____

NAME OF SPOUSE _____

PATIENT'S NAME (if patient is a child) _____

STREET ADDRESS _____

CITY, STATE, ZIP _____

BUSINESS ADDRESS _____

PHONE: Res _____ Cell _____ Bus. _____

LANDLORD _____ PHONE _____

PATIENT EMPLOYED BY _____

PRESENT POSITION _____ HOW LONG? _____

SPOUSE EMPLOYED BY _____ HOW LONG? _____

PRESENT POSITION _____ HOW LONG? _____

REFERRED BY _____

PATIENT'S SOCIAL SECURITY NUMBER _____

SPOUSE'S SOCIAL SECURITY NUMBER _____
(Parent's Social Security No. if patient is a child)

NAME OF DENTAL INSURANCE COMPANY _____

POLICY NUMBER _____

INSURANCE ADDRESS _____

WHO WILL PAY THIS ACCOUNT? _____

I WILL BE PAYING TODAY BY CASH _____ CHECK _____ CREDIT CARD _____

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 on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ *Date* _____
Signature (Parent if minor)

_____ *Date* _____
Signature (Parent if minor)

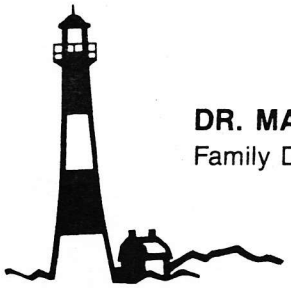
_____ *Date* _____
Signature (Parent if minor)

_____ *Date* _____
Signature (Parent if minor)

_____ *Date* _____
Signature (Parent if minor)

_____ *Date* _____
Signature (Parent if minor)

CONTACT/BILLING EMAIL: _____



DR. MARK J. HARRIS, DMD
Family Dentistry

PLEASE PRINT

Date _____

(Dr.) (Mr.) (Mrs.) (Miss) (Ms.) _____

Date of Birth _____ Age _____ Sex _____

Purpose of Call _____

HEALTH HISTORY

Have you ever had any of the following?

- Rheumatic Fever . . . . . Yes ☐ No ☐
- Diabetes (sugar disease) . . . . . Yes ☐ No ☐
- High Blood Pressure . . . . . Yes ☐ No ☐
- Low Blood Pressure . . . . . Yes ☐ No ☐
- Heart Trouble . . . . . Yes ☐ No ☐
- Tuberculosis . . . . . Yes ☐ No ☐
- Respiratory Disease . . . . . Yes ☐ No ☐
- Rheumatism or Arthritis . . . . . Yes ☐ No ☐
- Asthma . . . . . Yes ☐ No ☐
- Heart Murmur . . . . . Yes ☐ No ☐
- Hepatitis/Jaundice . . . . . Yes ☐ No ☐
- Venereal Disease . . . . . Yes ☐ No ☐
- Anemia . . . . . Yes ☐ No ☐
- Leukemia . . . . . Yes ☐ No ☐
- Stroke . . . . . Yes ☐ No ☐
- Tumors or Growths . . . . . Yes ☐ No ☐

Have you ever had an allergic reaction to any of the following?

- Aspirin . . . . . Yes ☐ No ☐
- Penicillin . . . . . Yes ☐ No ☐
- Other Medicine _____

Have you ever experienced an unusual reaction to a dental injection, e.g. (novocain)? . . . . . Yes ☐ No ☐

Have you ever experienced prolonged bleeding or healing complications following a cut or tooth extraction? . . . . . Yes ☐ No ☐

Are you presently taking any medication? . . . . . Yes ☐ No ☐

If Yes, what? _____

Have you ever had a blood, liver, or kidney disease? . . . . . Yes ☐ No ☐

Do you have pain in or near your ears? . . . . . Yes ☐ No ☐

Do you clench or grind your teeth? . . . . . Yes ☐ No ☐

Is any part of your mouth sensitive to pressure, cold, hot or sweets? . . . . . Yes ☐ No ☐

Do your gums bleed? . . . . . Yes ☐ No ☐

Sexually transmitted diseases or "AIDS"? . . . . . Yes ☐ No ☐

Are you under a physician's care now? . . . . . Yes ☐ No ☐

If Yes, physician's name _____

Physician's address _____
(No.) (City) (State) (Zip Code)

Physician's telephone number ( ) _____

Is there any other personal or family history which should be known? _____

If Yes, what? _____ Are you pregnant? _____

The undersigned hereby authorizes any physician, dentist, pharmacy or other provider of medical or dental services to release any and all information concerning treatment or prescriptions given to me (or to dependent child _____) and to furnish photostatic copies of any such information to any person requesting same. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or other health practitioners.

I understand that the above information is being relied on for accuracy and completeness to assure that proper dental services can be rendered to the patient. The undersigned further hereby expressly guarantees payment in full of any charges for services rendered by the Dentist and his staff. There shall be included in the computation of the amount due, an amount for reasonable attorney's fees in any collection proceedings as well as all disbursements, allowances, and costs provided by law.

A photostatic copy of this authorization shall be considered as effective and valid as original.

Patient's signature _____
(Guardian, if minor)