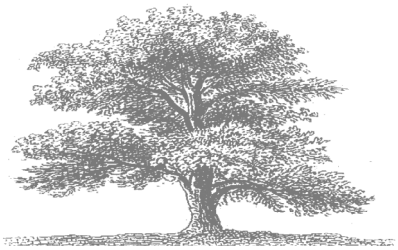


TARA GRIFFIN, DDS
Dentistry with a Delicate Touch

Welcome!

We are pleased to welcome you into our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient # _____
SS#/SIN _____
Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate____/____/____ Home Phone _____
Address _____ City _____ State _____ ZIP _____
Email _____ Cell Phone _____
Check the Appropriate Box: ❑Minor ❑Single ❑Married ❑Divorced ❑ Widowed ❑Separated
If Student, Name of School/College _____ City _____ State _____ ❑Full Time ❑Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ ZIP _____
Spouse or Guardian's Name _____Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____
Address_____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate____/____/____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ❑Yes ❑No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
❑Cash ❑Personal Check Credit Card ❑VISA ❑MasterCard ❑ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured_____ Relationship to Patient_____
Birthdate_____/_____/_____ SS#/SIN _____ Date Employed_____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ ZIP _____
Insurance Company_____ Group# _____ Policy# _____
Ins. Co. Address _____ City _____ State _____ ZIP _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ Yes ❑ No IF YES, COMPLETE THE FOLLOWING.

Name of Insured_____ Relationship to Patient_____
Birthdate_____/_____/_____ SS#/SIN _____ Date Employed_____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State _____ ZIP _____
Insurance Company_____ Group# _____ Policy# _____
Ins. Co. Address _____ City _____ State _____ ZIP _____
How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam _____

1. Are you under a physician's care now?..... ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? .....☐ Yes ☐ No
   If yes, please explain _____
   _____
3. Are you taking any medication(s) including non-prescription medicine?..... ☐ Yes ☐ No
   If yes, what medication(s) are you taking? _____
   _____
4. Have you ever taken Fen-Phen/Redux?.....☐ Yes ☐ No
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?..... ☐ Yes ☐ No
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours?..... ☐ Yes ☐ No
7. Do you use tobacco?..... ☐ Yes ☐ No
8. Do you use controlled substances?..... ☐ Yes ☐ No
9. Do you have or have you had any of the following?

10. Are you wearing contact lens?.....☐ Yes ☐ No
11. Are you allergic to or have you had any reactions to the following?
    - Local Anesthetics (e.g. Novocain)……☐ Yes ☐ No
    - Penicillin or any other Antibiotics……☐ Yes ☐ No
    - Sulfa Drugs……☐ Yes ☐ No
    - Barbiturates……☐ Yes ☐ No
    - Sedatives……☐ Yes ☐ No
    - Iodine ……☐ Yes ☐ No
    - Aspirin ……☐ Yes ☐ No
    - Any Metals (e.g. nickel, mercury, etc.)… ☐ Yes ☐ No
    - Latex Rubber ……☐ Yes ☐ No
    - Other (please list)_____
12. Do you have a persistent cough/throat clearing not associated with a known illness (lasting more than 3 weeks)?.....☐ Yes ☐ No
13. Women Only:
    - a.) Are you pregnant or think you may be? .....☐ Yes ☐ No
    - b.) Are you nursing?..... ☐ Yes ☐ No
    - c.) Are you taking oral contraceptives?..... ☐ Yes ☐ No

High Blood Pressure	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Chest Pains	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Cardiac Pacemaker	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Swollen Ankles	☐ Yes ☐ No	Angina	☐ Yes ☐ No	Hay Fever / Allergies	☐ Yes ☐ No
Fainting / Seizures	☐ Yes ☐ No	Frequently Tired	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Epilepsy/ Convulsions	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Leukemia	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Joint Replacement or Implant	☐ Yes ☐ No	Heart Trouble	☐ Yes ☐ No
Kidney Diseases	☐ Yes ☐ No	Hepatits / Jaundice	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
AIDS or HIV Infection	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No	Stomach Troubles/Ulcers	☐ Yes ☐ No	Other _____	☐ Yes ☐ No

Patient Dental History

Name of Previous Dentist and Location_____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?..... ☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐ Yes ☐ No
4. Do you feel pain to any of your teeth?.....☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
6. Have you had any head, neck or jaw injuries?..... ☐ Yes ☐ No
7. Have you ever experienced any of the following problems in your jaw?
   - Clicking.....☐ Yes ☐ No
   - Pain (joint, ear, side of face)…… ☐ Yes ☐ No
   - Difficulty in opening or closing…….. ☐ Yes ☐ No
   - Difficulty in chewing…… ☐ Yes ☐ No
8. Do you have frequent headaches?..... ☐ Yes ☐ No
9. Do you clench or grind your teeth? …… ☐ Yes ☐ No
10. Do you bite your lips or cheeks frequently?..... ☐ Yes ☐ No
11. Have you ever had any difficult extractions in the past? ☐ Yes ☐ No
12. Have you ever had any prolonged bleeding following extractions?..... ☐ Yes ☐ No
13. Have you had any orthodontic treatment?.....☐ Yes ☐ No
14. Do you wear dentures or partials?.....☐ Yes ☐ No
    If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?..... ☐ Yes ☐ No
16. Do you like your smile?.....☐ Yes ☐ No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date_____

TARA GRIFFIN, DDS
Dentistry with a Delicate Touch

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO 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 04/14/03 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 an 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 we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about 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 or 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 health care 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 authorization 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 except 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, you 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 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 your 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 will not use 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 or 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 you health or safety or the health or safety of others.

TARA GRIFFIN, DDS
Dentistry with a Delicate Touch

NOTICE OF PRIVACY PRACTICES (CONT.)

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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 voicemail messages, postcards, 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 that 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.____ for each page and $ N/A 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 you health information in that format. If you prefer, we will prepare a summary or an explanation of 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 that 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 Notice: 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. I

f you are concerned that we may 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 make to amend or restrict the use or disclosure of your health information or to have us communicate 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 US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human 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 US Department of Health and Human Services.

Contact Officer: Dr. Tara Hall Griffin

Telephone: (843) 971-1993

Fax: (843) 971-1276

E-mail: www.drtaragriffin.com

Address: 1039 Hwy 41, Station 41, Mt. Pleasant, SC 29466

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office'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, but acknowledgement could not be obtained because:

_____ Individual Refused to Sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining the acknowledgement

_____ Other (Please Specify)

_____

_____

_____

TARA GRIFFIN, DDS
Dentistry with a Delicate Touch

FINANCIAL POLICY

Dr. Griffin and her staff are committed to providing you and your family with the best possible care. Your clear understanding of our financial policy is important to the success of our relationship with you, and we are pleased to discuss our professional fees with you at anytime. We have prepared the following information to assist you in your planning and provide two copies, one for you to sign and return to our office and one for your records.

For Our Patients With Insurance

We are happy to file the forms necessary to see that you receive the full benefit from your primary insurance coverage; however, we cannot guarantee any estimated coverage. Because your insurance policy is an agreement between you and your insurer, we ask that our patients be directly responsible for all copayments and pay the estimated patient responsibility, (EPR), a the time of service. We remind you that the criteria we use to establish our fees may not necessarily correspond with the criteria used by your insurer. For that reason, you may be responsible for amounts not covered by your policy. If an ALTERNATE treatment or material is substituted by the insurance company for the treatment you receive, you are responsible for the fees exceeding the insurance fee allowance. Although we will do everything possible to see that you receive your maximum benefit, please be aware that we will expect payment in full from you if we have not received insurance payment within 60 days of treatment.

For Our Self-Pay Patients

Payment is expected at the time of service.

Payment Options

We accept payment by Cash, Check, Visa, CareCredit or MasterCard. For those patients interested in exploring financing options for major procedures, we will gladly provide you with information on companies who offer such services.

The Financial Policy continues on the backside of this page.

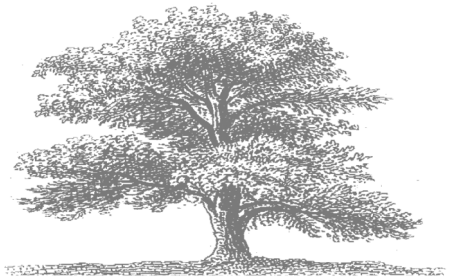
Thank you for reviewing our Financial Policy.
Please contact us with any questions.

MY SIGNATURE BELOW INDICATES MY ACCEPTANCE OF DR. GRIFFIN'S FINANCIAL POLICIES.

_____ _____

SIGNATURE DATE

Tara Griffin, DDS | 1039 Hwy 41, Mt. Pleasant, SC 29466 | P: (843) 971-1993 F: (843) 971-1276 | drtaragriffin.com



TARA GRIFFIN, DDS

Dentistry with a Delicate Touch

FINANCIAL POLICY (CONT.)

Missed Appointment Fee

The second time a patient does not present on time for an appointment, or cancels with less than 24-hour notice; it is our custom to assess a $50.00 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their record to another office. Exceptions will be considered on an individual basis.

Divorce

After a divorce or separation, the patient authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires that other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge

A finance charge will be imposed on each item of your account, which has not been paid within **sixty (60) days** of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of and and one-half percent (1 1/2 %) per month or an ANNUAL PERCENTAGE RATE of eighteen percent (18%). The finance charge on your account is computed by applying the periodic rate (1 1/2 %) to the "overdue balance" of your account. The "overdue balance" is calculated by taking the balance owed sixty (60) days ago and subtracting any payment or credits applied to the account during that time.

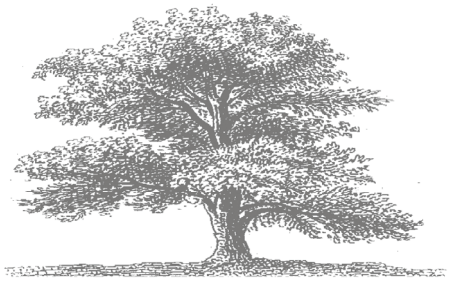
Past Due Accounts

If your account becomes past due, we will take the necessary steps to collect the balance owed. If we have to refer your account to a collection agency or if the account requires legal action, you agree to pay all the collection costs and legal fees that are incurred. Consideration of reinstatement to active patient status would require payment of balance and all collection costs with the agreement that future changes are paid in full at the time of service.

Returned Checks

In the rare case of a check returned for insufficient funds, we will assess a processing fee of $30.00 on your account and will allow one week for receipt of a money order for the account balance and fee.

Tara Griffin, DDS | 1039 Hwy 41, Mt. Pleasant, SC 29466 | P: (843) 971-1993 F: (843) 971-1276 | drtaragriffin.com



TARA GRIFFIN, DDS

Dentistry with a Delicate Touch

SIGNATURE ON FILE

PATIENT'S NAME _____

Last **First** **Middle Initial**

I hereby authorize payment directly to **DR. TARA GRIFFIN, DDS** of the benefits otherwise payable to me.

_____

Signature (Insured Person)

_____

Date

Signature is valid for two years from the above date, unless revoked by me at an earlier date.

Tara Griffin, DDS is authorized to provide any insurance company(s), claim administrator(s) and consulting healthcare professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of the coverage of the policy or contract, in force on this date only or for two years, which ever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE **DATE**