Welcome.

"Thank you for selecting our Facial Rejuvination team."

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient information: (Confidential)

Name _____
Preferred Name_____ **E-mail** _____
Soc. Sec. #_____ Birthdate _____ **Home Phone**_____
Address _____
City _____ State _____ Zip _____
Cell# _____ Pager _____ Work _____
Check appropriate line: Minor ____ Single ____ Married ____ Separated ____ Divorced ____Widowed ____

Patient's or parent's employer _____ Work number _____
Business address _____ City _____ State _____ Zip _____
Spouse or parent name _____ Employer _____ **Work Phone** _____
Person to contact in case of emergency _____ Phone _____

Whom may we thank for referring you? _____

Responsible Party:

Relationship
Name of person responsible for this account _____ to patient _____
Address _____Home phone _____
Birthday _____ Employer _____Work phone _____
SS#_____ Is this person currently a patient in our office? ____ Yes ____

Unless otherwise indicated, we would like to periodically send you information via e-mail in regards to dental issues of concern and to confirm your reserved appointment time and date. Use of your (confidential) e-mail address is for Patient communication only and will not be shared with any other person or business. If you do not wish to be contacted via E-mail, please indicate by initialing here_____.

_____ _____
Signature of patient/responsible party Date

Medical History

Physician_____ Office Phone_____ Date last Exam_____

	Yes	No
1. Are you under medical treatment now?	___	___
2. Have you ever been hospitalized for any surgical	___	___
Operation or serious illness within the last 5yrs?	___	___
If yes please explain _____		
_____		
3. Are you taking <u>any medication(s)</u> including		
Non-prescription medicine, such as vitamin E, gingko biloba,		
Garlic, ginseng, ginger, chamomile, or green tea?		
Please list:_____		
4. Do you take aspirin or medicine like aspirin daily?	___	___
5. Have you taken phen-fen/redux?	___	___
6. Do you use tobacco?	___	___
7. Do you use controlled substances?	___	___
8. Are you wearing contact lenses?	___	___

10. Are you allergic to or have you had any reactions to any of the following?	Yes	No
Local Anesthetics (Novocaine)	___	___
Penicillin	___	___
Sulfa Drugs	___	___
Barbiturates	___	___
Sedatives	___	___
Aspirin	___	___
Iodine	___	___
Codeine	___	___
Any Metals (Nickel, Mercury)	___	___
Latex Rubber	___	___
Formaldehyde or Aldehydes	___	___
Other:_____	___	___

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High/low Blood Pressure	___	___	Heart Disease	___	___	Chest Pain	___	___
Heart Attack	___	___	Cardiac Pacemaker	___	___	Easily Winded	___	___
Asthma	___	___	Heart Murmur	___	___	Stroke	___	___
Swollen Ankles	___	___	Trauma to the Mouth	___	___	Hay Fever/Allergies	___	___
Fainting/Seizures	___	___	Tuberculosis	___	___	Stomach Trouble/Ulcer	___	___
Bleeding Disorder	___	___	Anemia	___	___	Radiation/Chemotherapy	___	___
Emphysema	___	___	Glaucoma	___	___	Thyroid Problems	___	___
Epilepsy/Convulsion	___	___	Cancer	___	___	Recent Weight Loss	___	___
Leukemia	___	___	Arthritis	___	___	Liver Disease	___	___
Diabetes	___	___	Joint Replacement or Implant	___	___	Drug Addiction	___	___
Kidney Disease	___	___	Hepatitis or Jaundice	___	___	Respiratory Problems	___	___
Aids or HIV infection	___	___	Sexually Transmitted Disease	___	___	Mitral Valve Prolapse	___	___

Other: _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	___	___	9. Do you clench or grind you teeth?	___	___
2. Are your teeth sensitive to hot/cold liquids/food?	___	___	10. Do you bite your lips or cheek frequently	___	___
3. Are your teeth sensitive to sweet/sour liquids/food?	___	___	11. Have you had any difficult extractions		
4. Do you feel pain in any of your teeth?	___	___	In the past?	___	___
5. Do you have any sores or lumps in/near your mouth	___	___	12. Have you ever had any prolonged		
6. Have you had any neck head or jaw injuries?	___	___	bleeding following extractions?	___	___
7. Have you ever experienced any of the following	___	___	13. Have you had any orthodontic treatment?	___	___
Problems with your jaw?			14. Do you wear dentures or partials?	___	___
Clenching	___	___	15. Have you ever received oral hygiene		
Pain	___	___	instructions on your teeth and gums?	___	___
Difficulty in Opening or Closing	___	___	16. Do you snore?	___	___
Difficulty in Chewing	___	___	17. Do you suffer from sleep apnea?	___	___
8. Do you have frequent headaches?	___	___			

Women only:

Are you pregnant or think you may be?	___	___
Are you nursing?	___	___
Are you taking hormonal contraceptives?	___	___

Men only:

Do you take Erectile Dysfunction Drugs?
Viagra ___ ___

Misc. Information:

_____
_____

_____ _____
Patient or Guardian Signature Date

Pre Op Questions

Are you taking or have you ever taken any of the following? Please check yes or no.

Boneva- (Ibandronate)	Yes_____No_____	Xgeva-	Yes_____ No_____
Actonel- (Risedronate)	Yes_____No_____	Bisphosphonates-	Yes_____ No_____
Fosomax- (Alendronate)	Yes_____No_____	Kava-	Yes_____ No_____
Zometa- (Zoledronic Acid)	Yes_____No_____	Valerian-	Yes_____ No_____
Aredia- (Pamidronate)	Yes_____No_____	St. Johns Wort-	Yes_____ No_____
Reclast	Yes_____ No_____	Echinacea-	Yes_____ No_____
Prolia- (Denosumab)	Yes_____No_____	Xgeva-	Yes_____ No_____
Didronel- (Etidronate)	Yes_____No_____	Skelid-	Yes_____ No_____

Feverfew-	Yes_____ No_____	Saw Palmetto-	Yes_____ No _____
Garlic-	Yes_____ No_____	Ephedra-	Yes_____No _____
Ginger -	Yes_____ No_____	Green Tea-	Yes_____ No_____
Ginkgo-	Yes_____ No_____	Chamomile-	Yes_____No_____
Ginseng-	Yes_____ No_____	Goldenseal -	Yes_____ No_____

Any other Herbal Supplements not previously mentioned?

_____

_____

Sign_____ Date_____/_____/_____

Sign_____ Date_____/_____/_____

Stephen P. Lester, D.D.S., P.A.
Treatment Scheduling Agreement

By accepting Dr. Lester as your primary facial rejuvenation provider, you are participating in a tradition of exceptional care established many years ago. As part of our family of patients, it is vital that we have an open line of communication. Your access to us and our access to you is the foundation to a long lasting relationship.

Trying to accommodate every patient's individual needs and work schedules can be a difficult task, but we always do our best. We work very hard to stay on schedule so that you will not spend unnecessary time waiting for your appointment. To us, a scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When you miss an appointment the result is a permanent loss of that time which could have been used to treat other patients in need.

We ask that when you schedule an appointment, you make every effort to keep that commitment. Since various circumstances or personal emergencies may keep you from your commitment with us, we always take that into consideration when receiving a last minute schedule change. If, however, you must cancel on short notice you will be asked to pay a $50.00 deposit for your facial rejuvenation care prior to making your next appointment. If you cancel the prepaid appointment on short notice you will forfeit this deposit. If you arrive more than ten minutes late for your appointment, it is often necessary to reschedule. The same forfeiture penalties apply if we must reschedule.

When you find that you cannot keep your scheduled appointment, we ask you to provide a minimum of two full business days' notice. Your cooperation will allow us to schedule other patients in need of our care. For your convenience, we have a scheduling coordinator available to you Monday through Friday.

If you have any questions regarding this agreement, please do not hesitate to contact us. With your understanding and cooperation, we can work together to achieve your facial rejuvenation.

_____ _____

Signature of patient/ Responsible party ***Date***

" Stephen P. Lester, D.D.S., P.A. "
"Financial philosophy."

This statement is to inform you of our financial philosophy. We are committed to providing you with the highest quality of care regarding your facial rejuvenation utilizing only the best materials and education available. In our process of doing so, we have formulated a financial policy to continue to provide excellent service to you and minimize our administrative costs.

Our office accepts cash, debit cards, MasterCard, Visa, and Discover.

Charges may be incurred for broken appointments and appointments cancelled or rescheduled without two full business days advance notice.

I, the patient, agree to pay any and all collection costs and attorney's fees associated with collection of any account.

If you have any questions regarding our financial policy, please do not hesitate to ask. We are committed to providing you with the most positive experience in facial rejuvenation.

_____ _____

Signature of patient/responsible party Date

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, hereby authorize Stephen P. Lester, DDS, PA and

Associates, (hereafter collectively referred to as ñPracticeò) to use and disclose the entire medical record concerning _____in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given the opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, itôs employees and agents for any and all liability (including, but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Practice to use and disclose verbally, by mail, fax, or unencrypted e-mail, the following types of super-confidential information as sated in the NOPP (initial where appropriate):

- ☐ HIV records (including HIV test results) and sexually transmissible disease_____
- ☐ Alcohol and substance abuse diagnosis and treatment records_____
- ☐ Psychotherapy records_____

COMPLETE AS APPLICABLE

1. Please send a copy of my records (include information from other health-care providers that it may contain) to _____at_____.
   I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal and state law.
2. Please allow_____ to pick up a copy of my records (including information from other health-care providers that it may contain).
   The copies will be ready on _____.
3. I acknowledge I will be charged a copying cost in the amount of $0.00.

By Patient:_____
(Print name and sign)
Date:_____

OR

By Patientôs Representative:_____
(Print name, sign and describe authority
Date:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Stephen P. Lester, DDS, PA,

This _____ day of _____, 20__. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____

PLEASE PRINT YOUR NAME

_____

PLEASE SIGN YOUR NAME

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority:

_____

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Stephen P. Lester, DDS, PA

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

- ♦ It was emergency treatment.
- ♦ I could not communicate with the patient.
- ♦ The patient refused to sign.
- ♦ The patient was unable to sign because: _____
- ♦ Other (please describe) _____

Signature of privacy officer: _____