

WELCOME!

Our staff is delighted that you have chosen us to care for your dental needs.

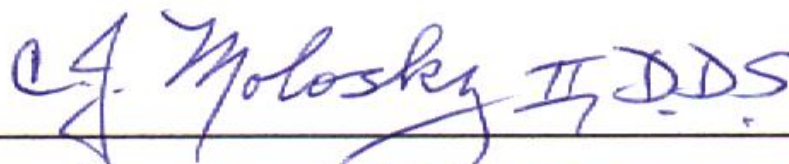
We are both graduates of the University of Pacific School of Dentistry. We are proud to provide personalized, professional, gentle care for adults and children in the community. We believe that your comfort during treatment is of the utmost importance and we will do everything to ensure that your office visit will be pleasant.

We have enclosed a patient information form so that you may complete it at your earliest convenience. Please bring it with you to your appointment and, if you have insurance, bring a copy of your insurance information. We are always happy to assist you with your insurance.

We are conveniently located on the corner of Post and Mason near Union Square. Parking is available in this building. The entrance to our parking facility is located on Mason Street between Sutter and Post. We are very happy to have you as a new patient. Our primary purpose is to solve our patient's dental problems and we sincerely look forward to meeting you at your scheduled appointment.

Sincerely,

Charles J. Molosky, D.D.S.,

Handwritten signature of Charles J. Molosky II, D.D.S. in blue ink, written over a horizontal line.

Michael J. Molosky, D.D.S.

Handwritten signature of Michael J. Molosky, D.D.S. in blue ink, written over a horizontal line.

and Staff

Name _____ Date _____

Your answers to all these questions will aid your dentist in the proper treatment of your case. All information is confidential.

When a space is provided, please put an in the box to indicate your answer. Where lines are provided, please write in your answer.

OFFICE USE ONLY	
<input type="checkbox"/>	Acute cond.
<input type="checkbox"/>	Allergy
<input type="checkbox"/>	Blood dysc.
<input type="checkbox"/>	Cardiac
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Medication
<input type="checkbox"/>	PN problem
<input type="checkbox"/>	Pregnant
<input type="checkbox"/>	Protection
<input type="checkbox"/>	Resp. cond.

- Have you come to this office for the relief of pain? yes no
If "yes" where is the pain? _____
Have you had the pain more than three weeks? yes no
- Have you been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? yes no
- Has a dentist or hygienist shown you how to clean your teeth? yes no
If "yes" do you use this method of cleaning your teeth now? yes no
- Do you have sores, swellings or blisters on your gums, cheeks, or lips? yes no
If "yes" have they been present longer than 3-4 weeks? yes no
- Have you had orthodontic treatment to straighten your teeth? yes no
- Please check any items below that you use often in mouth care.

<input type="checkbox"/> hand toothbrush	<input type="checkbox"/> electric toothbrush
<input type="checkbox"/> dental floss	<input type="checkbox"/> gum stimulators, toothpicks stimudent
<input type="checkbox"/> rubber tip	<input type="checkbox"/> water spray
<input type="checkbox"/> other	
- How would you describe your general health?
 poor fair good
- Are you now being treated or have you been treated within the last year by a physician? yes no
- Have you ever had an unusual reaction to dental anesthesia (gas or shots)? yes no
- Following injuries or dental treatment, have you had bleeding problems? yes no
- Is there a history of diabetes in your family? yes no
- Are you thirsty most of the time? yes no
- Have you recently lost weight unintentionally? yes no
- Do you urinate more than six times a day? yes no
- Have you had eye trouble recently? yes no
- Do injuries or cuts take longer to heal now than they did previously? yes no
- Does your mouth feel dry or do you have a burning sensation of lips or tongue? yes no
- Have you taken or been given injections of steroids such as cortisone? yes no

Make a checkmark against the following only if your answer is "Yes"

Have you become sick from, shown an allergy to, or been told not to take:

- Antibiotics (penicillin, sulfa, etc.)?
- Codeine, aspirin, vicodin?
- Novocaine or other dental anesthetics?
- Other drugs or medications? _____

Are you now taking or using medications for:

- Diabetes (pills or shots)
- Nerves (tranquilizers)
- Sleeping
- Heart or blood pressure (digitalis, nitroglycerin, reserpine)
- Blood (liver or iron pills, etc.)
- Stomach trouble (ulcer, other)
- Headache
- Arthritis or rheumatism
- Allergy

Are you now

- Pregnant
- On a prescription diet
- Using thyroid
- Using hormones (including birth control pills)
- Using anticoagulents
- Using Dilantin
- Using other medicines _____

Have you ever had any of the following:

- Heart disease, Mitral Valve Prolapse, Pacemaker
- Shortness of breath without exercise or when lying down
- Swelling of ankles or feet
- Pain, pressure, or tight feeling in chest
- Heart attack
- Rheumatic fever, heart murmur
- High blood pressure
- Fainting spells, convulsions, epilepsy
- Frequent headaches (two or three a week)
- Headaches when lying down
- Nervous breakdown, psychotherapy
- Lung trouble (TB, asthma, emphysema)
- Hepatitis, liver disease, jaundice
- Arthritis, sore joints
- Diabetes
- Excessive bleeding
- Blood trouble, anemia, leukemia
- VDX (syphilis, gonorrhea)
- Cancer
- Artificial heart valves or artificial joints
- Kidney problems
- High risk for HIV

Signature _____

Date _____

Statement of Office Policy

Effective 07/01/06

We appreciate your confidence in us and we will make every effort to provide you with cost effective, comfortable and attractive dental care. Our ultimate desire is the preservation of your natural teeth for life. Your cooperation will enable us to achieve this goal.

We feel that a definitive understanding of financial arrangements is necessary so that you may plan your dental budget accordingly.

- **If you have dental insurance, we expect your co-payment at the time services are rendered.** For your convenience, we now accept CARECREDIT, MASTERCARD, VISA, AMERICAN EXPRESS OR YOU CAN USE CHECK, CASH, OR MONEY ORDER.
- If you do not have insurance, financial arrangements must be made before any work is started!
- A charge of \$100 will be made for broken appointments and appointments cancelled without 48 hours notice.
- A charge of \$30 will be charged for all returned checks.

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.

I HAVE READ THE ABOVE:

Signature _____

Date _____

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- The dental practice has always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor who we may involve in your case.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with our health information beyond the able normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. **If you also want a copy of your records, we may charge a reasonable fee for the copies.**
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Ave., S.W. Rm. 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, or for more information or assistance regarding our health information privacy, please contact **Dr. Molosky at (415) 421-6766.**
- This notice goes into effect as of April 14, 2003.

Consent for Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the office.

Charles J. Molosky II, D.D.S. or Michael J. Molosky, D.D.S.
490 Post Street, Suite 1540
San Francisco, CA 94102
(415) 421-6766

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include COMPLETED Consent in the patient's chart.**