R. Alan May, DDS
Creating Healthy Smiles

WELCOME TO OUR PRACTICE

On behalf of our entire team, let me welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Personal Information Sheet and Medical History questionnaire that should be filled out prior to your first appointment with us.

Be sure to visit our website at www.DrMayDentistry.com. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

R. Alan May, DDS

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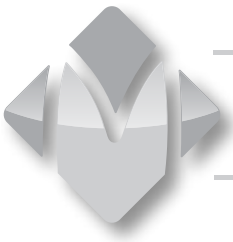

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PATIENT REGISTRATION

Welcome to our office. Please be kind enough to answer the following questions. Thank you so much for being our guest!

M F S M D W

Name (Last) (First) (Middle) Date of Birth Sex Marital Status Social Security Number

How would you like to be addressed? Email Address Cell Phone Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation Driver's License Number

Business Address (Street) (City) (State) (ZIP Code) Business Phone Number

PERSON RESPONSIBLE FOR ACCOUNT

Who is responsible for account? self spouse parent/guardian other
(Please fill in the following information if the person responsible is different from self.)

Name (Last) (First) (Middle) Social Security Number

Home Address (Street) (City) (State) (ZIP Code) Home Phone Number

Name of Employer Occupation Business Phone Number

INSURANCE INFORMATION

Insured Member (Last) (First) (Middle) Relationship SSN Date of Birth

Name of Employer Occupation Business Phone Number

Business Address (Street) (City) (State) (ZIP Code) Dental Insurance Co.

Group Number _____ ID Number _____

How did you hear of our office?_____

If patient was assisted with this form, enter name of person assisting:

_____ _____
Print name Sign name Date

_____ _____
Signature of patient Date

7051 Williamson Road • Roanoke, VA 24019 • (540) 366-1001
www.DrMayDentistry.com

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

General health (please check): EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR ❑ Name of physician _____
Physician's Address _____ Telephone Number _____ Date of Last Physical _____
Are you now under the care of a physician? Yes ❑ No ❑
Are you pregnant or do you think you may be pregnant? Yes ❑ No ❑ If yes, expected delivery date: _____
Are you nursing? Yes ❑ No ❑ Are you taking birth control pills? Yes ❑ No ❑
Do you smoke? Yes ❑ No ❑ If yes, how much? _____
Are you taking any medication now? Yes ❑ No ❑ If yes, names of medications and problems for which they are taken:
Medication 1) _____ Taken for _____ 3) _____ Taken For _____
2) _____ Taken for _____ 4) _____ Taken For _____

Do you use tobacco? Yes ❑ No ❑
Have you ever required a blood transfusion? Yes ❑ No ❑
Do you or have you used controlled substances? Yes ❑ No ❑
Have you ever taken Fen-Phen or Redux? Yes ❑ No ❑
Are you wearing contact lenses? Yes ❑ No ❑
Do you bruise easily? Yes ❑ No ❑

Have you ever had (please check-mark appropriate boxes):

Abnormal blood pressure High ❑ Low ❑ No ❑
AIDS/HIV Yes ❑ No ❑
Anemia Yes ❑ No ❑
Arthritis Yes ❑ No ❑
Asthma or hay fever Yes ❑ No ❑
Allergies Yes ❑ No ❑
Back problems Yes ❑ No ❑
Cancer Yes ❑ No ❑
Chemical dependency Yes ❑ No ❑
Cold sores/Fever blisters Yes ❑ No ❑
Common cold Yes ❑ No ❑
Congenital heart lesions Yes ❑ No ❑
Diabetes Yes ❑ No ❑
Drastic weight loss Yes ❑ No ❑
Eating disorders Yes ❑ No ❑
Epilepsy/Seizures Yes ❑ No ❑
Excessive urination and/or thirst Yes ❑ No ❑
Fainting spells Yes ❑ No ❑
Glaucoma Yes ❑ No ❑
Heart disease Yes ❑ No ❑
Heart murmur Yes ❑ No ❑
Heart surgery Yes ❑ No ❑
Hepatitis Yes ❑ No ❑
Jaundice Yes ❑ No ❑
Joint replacement or implant Yes ❑ No ❑
Kidney trouble Yes ❑ No ❑
Mental health care Yes ❑ No ❑
Lymph node enlargement (swollen glands) Yes ❑ No ❑
Mitral valve prolapse Yes ❑ No ❑
Night sweats Yes ❑ No ❑
Pacemaker Yes ❑ No ❑
Persistent diarrhea Yes ❑ No ❑
Prolonged bleeding Yes ❑ No ❑
Rheumatic fever Yes ❑ No ❑
Sexually transmitted disease Yes ❑ No ❑
Sinus trouble Yes ❑ No ❑
Swollen ankles Yes ❑ No ❑
Stroke Yes ❑ No ❑
Thyroid problem Yes ❑ No ❑
Tuberculosis or lung disease Yes ❑ No ❑
Ulcers Yes ❑ No ❑
X-ray treatments for cancer Yes ❑ No ❑

If you have entered "yes" to any of the above, please explain: _____

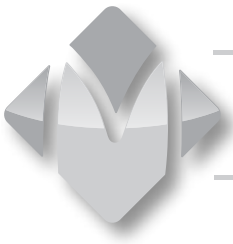
Are you allergic to or have you had reactions to:

Local anesthetics like Novocaine Yes ❑ No ❑
Penicillin or other antibiotics Yes ❑ No ❑
Sulfa drugs Yes ❑ No ❑
Barbiturates, sedatives, or sleeping pills Yes ❑ No ❑
Codeine Yes ❑ No ❑
Aspirin Yes ❑ No ❑
Iodine Yes ❑ No ❑
Any metal (e.g. gold, nickel, etc.) Yes ❑ No ❑
Latex/Rubber Yes ❑ No ❑
Tylenol Yes ❑ No ❑

Other (please list) _____
Have you had any other serious illness, hospitalization, or accident? _____

*Your signature indicates you have received a copy of the HIPAA law and Dental Materials forms and release our office to utilize any dental photographs for lecturing and educational purposes.

Signature: _____ Date: _____



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INSURANCE CLAIMS PROCESS

Our office is pleased that you have insurance benefits to help you with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?
We work with many companies. It is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer. Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL. WHY?
We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to visiting our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so that we may adjust accordingly.

INSURANCE DIDN'T PAY. NOW WHAT?
We bill your insurance as a courtesy. If insurance does not pay within 60 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Our office does request payment in full for your estimated portion at the time of service.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at your office, with R. Alan May, DDS.

Name:_____Date:_____

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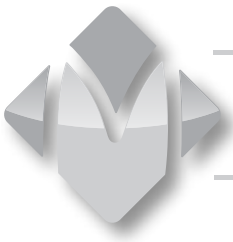
www.DrMayDentistry.com



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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____ 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. 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 our office at (540) 366-1001 or by mailing us at 7051 Williamson Road, Roanoke, VA 24019.

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 address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

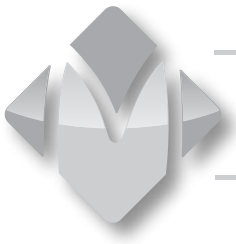
I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities,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

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.



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NOTICE OF PRIVACY PRACTICES. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection activities, and utilization review.
- *Health care operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.
- The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing this form, I agree to allow the use and disclosure of my medical record information for the purposes described above. A copy of this authorization (consent) form will be given to me.

Signature:_____Date:_____

Please contact us for more information:
R. Alan May, DDS
7051 Williamson Road
Roanoke, VA 24019
(540) 366-1001
www.DrMayDentistry.com

For more information about HIPAA or to file a complaint:
The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257 or Toll Free: 1-877-696-6775