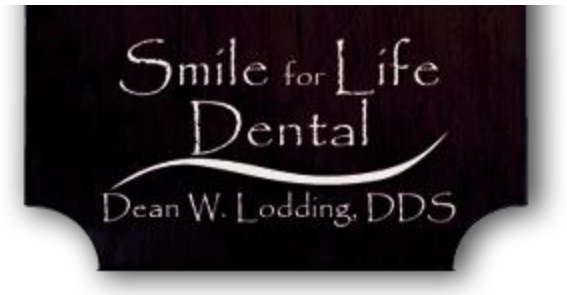


Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient

representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the

right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

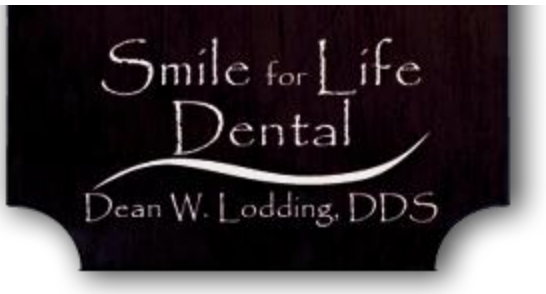
If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative 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 U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. 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 U.S. Department of Health and Human Services.

Telephone: (847) 697-1111 Fax: (847) 697-1114

Address: 2001 Larkin Ave Suite 120 Elgin, IL 60123

drlodding@yahoo.com



* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

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 acknowledgement
- ☐ Other (Please Specify)

_____

Smile for Life Dental

Patient Bill of Rights

Smile for Life Dental endorses a Patient Bill of Rights. We believe the following:

- We view our patients as family and will always do our best to provide exceptional care.
- The patient has the right to considerate and respectful care by Dr. Lodding and his team.
- The patient has the right to receive an emergency appointment within twenty-four hours of the emergency.
- A 24-hour cancellation notice for pending appointments is appreciated. We reserve the right to invoice a $90.00 fee for patients who have a history of two or more missed appointments that are not cancelled within the 24-hour time period. We respect our patients time and we hope this same courtesy is extended to us.
- In the event a scheduled appointment is changed by Smile for Life Dental, we will accommodate the patients schedule at their earliest convenience.
- If there is an opportunity to move a dental appointment to an earlier date or more convenient time for the patient, we reserve the right to contact the patient to do so, unless the patient has requested otherwise.
- The patient has the right to ask questions and obtain complete and current information concerning their diagnosis, treatment, and prognosis in terms the patient can reasonably be expected to understand.
- The patient has the right to receive an estimate of treatment fees and the privilege to examine and receive an explanation of their bill.
- The patient has the right to refuse any and all treatment and to be informed of any medical/dental consequences of their action.
- The patient has a right to every consideration of privacy concerning their own medical/dental care program limited only by State statutes, rules, and regulations at Smile for Life Dental.

Patient Update Contact Information

Name _____

Address _____

_____

☐ Home Phone _____

☐ Work Phone _____

☐ Cell Phone _____

~ Please check the best phone number to reach you.

E-mail Address (to confirm your reserved appointment time)

_____

☐ Please check this box if you do not have an e-mail address

☐ I have read and agree to accept the Patient Bill of Rights

Signature _____ Date _____

Smile for Life Dental

Dean W. Lodding, DDS

Patient Update Contact Information

Name _____

Address _____

_____

☐ Home Phone _____

☐ Work Phone _____

☐ Cell Phone _____

~ Please check the best phone number to reach you.

E-mail Address (to confirm your reserved appointment time)

_____

☐ Please check this box if you do not have an e-mail address

☐ I have read and agree to accept the Patient Bill of Rights

Signature _____ Date _____

Smile for Life Dental

Dean W. Lodding, DDS

Smile for Life Dental

New Patient Interview and Questionnaire

Name (please print) _____ Date _____

Who may I thank for referring you to our office? _____

1. Are you having any discomfort or problems with your teeth?
   ☐ Yes ☐ No If yes, please explain _____
2. When was the last time you saw your dentist? _____
3. Why did you leave your last dentist? _____
4. Was there anything particular thing you liked about your previous dentist or dental visits? _____
5. Was there any particular thing you didn't like about your previous dentist or dental visits? _____
6. What do you consider to be the most important factor in making sure your dental visit is a positive one?
7. What are your goals and desires regarding your dental health? _____
8. Do you have any particular concerns about your dental care or coming to the dental office? _____

Notes: _____

Smile for Life Dental

Dean W. Lodding, DDS

Smile for Life Dental is working to change professional and public behaviors and address the importance of oral health as it relates to whole body health. In order to properly diagnose and evaluate risk factors and health conditions related to the mouth, please provide us with your health care provider so that we may share the importance of this "oral-systemic connection".

Health Care Provider's Name: _____
Specialty: cardiology – internal medicine – women's health – other: _____
Address: _____
Phone: _____

Health Care Provider's Name: _____
Specialty: cardiology – internal medicine – women's health – other: _____
Address: _____
Phone: _____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I request and authorize Dr. Dean Lodding to release health care information to the health care provider named above.

☐ Signature on File

Signature of patient or authorized representative: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Smile for Life Dental

Personal Dental Health Evaluation

_____

Name (please print) Date

1. When was your last dental visit? _____
2. How often did you see the dentist? _____
3. Do any of the following cause you discomfort? ☐Hot ☐Cold ☐Chewing ☐Sweets
4. How often do you...
   - Brush your teeth? _____
   - Floss? _____
   - Rinse/Mouth Wash? _____
5. Do your gums bleed while cleaning? ☐Yes ☐No
6. Do your gums feel tender or swollen? ☐Yes ☐No
7. Have you had periodontal gum treatment? ☐Yes ☐No If yes, when? _____
8. Do you clench or grind your teeth? ☐Yes ☐No
9. Do your jaws ever...
   - ☐Feel tired or ache? ☐Click or pop?
10. Can you chew on both sides of your mouth? ☐Yes ☐No
    - Comfortably? ☐Yes ☐No
11. Do you have frequent...
    - Headaches? ☐Yes ☐No
    - Earaches? ☐Yes ☐No
    - Neck and shoulder pain? ☐Yes ☐No
12. Have you ever had orthodontic treatment (braces)? ☐Yes ☐No If yes, when? _____
13. Do you usually have many cavities? ☐Yes ☐No
14. Do you have any loose teeth? ☐Yes ☐No
15. Do you have any noticeable wear on your teeth? ☐Yes ☐No
16. Do you have any food traps on your teeth? ☐Yes ☐No
17. Do you have any missing teeth? ☐Yes ☐No
    - Have they been replaced? ☐Yes ☐No
      - If so, how? ☐Fixed bridge ☐Removable partial ☐Full denture ☐Dental Implant
18. Are you comfortable with the replacement? ☐Yes ☐No Please describe: _____
19. Do you lose fillings or break fillings? ☐Yes ☐No
20. Do you have any cracked or broken teeth? ☐Yes ☐No
21. Have you ever had an unpleasant dental experience? ☐Yes ☐No

Smile for Life Dental

Are You a Candidate for Cosmetic Dentistry?

Why change your smile?

Don't if you are happy with it, but ask yourself the following questions:

1. Do you like your smile? ☐Yes ☐No
2. Do you wish your teeth were whiter? ☐Yes ☐No
3. Do you feel you show too many or too few teeth when you smile? ☐Yes ☐No
4. Do you wish you had longer or shorter teeth? ☐Yes ☐No
5. Would you prefer wider or narrower teeth? ☐Yes ☐No
6. Are your teeth too square or too round? ☐Yes ☐No
7. Do you like the way your teeth are shaped? ☐Yes ☐No
8. Are you satisfied with the way your gums look? ☐Yes ☐No
9. Do you think you show too much or too little gum tissue when you smile? ☐Yes ☐No
10. When you look at your smile in the mirror, do you see a minor defect in your gums or in one of your teeth? ☐Yes ☐No
11. Do you have any thoughts or comments regarding your smile? ☐Yes ☐No

    If **yes**, please explain: _____

    _____

    _____

12. Would you like to discuss options to enhance your smile? ☐Yes ☐No