WELCOME TO BAY COLONY DENTISTRY

Thank you for choosing us for your dental care. Bay Colony Dentistry provides general dentistry for patients from one to one hundred years old in the oceanfront area of Virginia Beach. We are committed to using state of the art equipment, instruments, dental materials and techniques to help you preserve your teeth throughout your life. It is the intention of all personnel in this office to provide for your dental health needs as thoroughly and efficiently as possible. We therefore wish to acquaint you with the customary sequence of procedures followed in caring for the new patient in our practice.

THE FIRST APPOINTMENT

The initial appointment is spent conducting a thorough comprehensive examination. It includes a blood pressure screening, a review of your medical and dental history as well as any current medications you may be taking. Additionally, your mouth will be examined and the current condition of your gums and teeth will be charted in your electronic dental record. Digital x-rays, which reduce your exposure to radiation, will be taken along with a series of photographs. This information will be reviewed so we may accurately assess your dental needs. We think you will agree that the examination appointment is time well spent.

PREVENTATIVE ORAL HYGIENE APPOINTMENT

After your examination, you will be ready for the preventative and oral hygiene session. At this time we will discuss the latest scientific literature, products and techniques regarding the care of your teeth and gums. Specific approaches will be recommended based on your individual needs. Your teeth will be cleaned by a professional who is dedicated to you receiving maximum longevity from your natural dentition. This program is clearly one of the most valuable services we offer our patients.

After your preventative appointment your current dental health and treatment recommendations will be discussed. Immediate needs as well as long-term objectives will be outlined. Again, our recommendations will be based upon the goal of you receiving maximum longevity from your natural dentition. An estimate of the approximate costs of treatment will also be made at this time. We encourage you to ask any questions you have concerning your dental care.

FINANCIAL ARRANGEMENTS

Payment is expected when treatment is rendered. We accept cash, check, debit cards, Visa, MasterCard, Discover and American Express. For patients with extensive dental treatment needs, we accept Care Credit financing. An application for Care Credit can be downloaded from our website or provided by our Financial Coordinator. We are sensitive to your financial circumstances within the framework of sound business practices.

We participate in nearly all bonafide dental insurance plans and are eager to help you with your claims. In this regard we would like to offer the following tips:

1. Please bring a **photo ID** and your current **dental insurance** card.
2. Co-payment is expected at the time of service. You are responsible for any amount not covered by your plan.

Our goal is to make your visit to our office as convenient and comfortable as possible. We sincerely value your patronage and hope you will recommend us to your family and friends. If at any time you are in doubt about any treatment fee or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, to rectify an error and to preserve a friendship.

TREATMENT PROCEDURES

There are many new advances in treatment procedures, specialized services and new products. As an example, **Cosmetic Dentistry** includes whitening your natural dentition and using white filling materials to restore decayed portions of your teeth or to close gaps or spaces between your teeth. In office whitening as well as take home whitening are two very effective cosmetic procedures that are regularly available at Bay Colony Dentistry.

Bay Colony Dentistry also offers **endodontic** (root canals), **oral surgery** (extractions), minor **orthodontic** (Invisalign), **pedodontics** (children's dentistry), **periodontic** (gums and bone treatments), **prosthedontic** (crowns, bridges, implants and dentures) and **restorative** (fillings) services as well as protective **mouth guards** for sports and bruxing (teeth grinding).

We believe in providing a pleasant dental experience for all our patients but we are especially proud of our ability to provide **a fun oral health care foundation and dental home** for our **pediatric** patients.

CONTINUING CARE VISITS

Upon completion of your dental treatment you will be able to schedule your continuing care treatment. These appointments include an exam to review your current oral health, a preventative cleaning and a fluoride application. Our goal is to prevent minor dental needs from becoming big or expensive problems. Preventative dentistry is the best and least expensive dentistry, but it can easily be overlooked in our busy fast paced lives. Please don't miss these periodic exams and preventative cleaning services. If you think you are overdue for this important service, please call us and we will verify it for you.

EMERGENCY VISITS AND AFTER HOURS CARE

Unfortunately, accidents causing trauma to the teeth can happen at the least convenient times. Delaying dental preventative treatments and care can result in odontogenic (tooth) pain and infection. If you are *not a patient of record* at Bay Colony Dentistry and your first appointment with us is due to pain or infection, we will provide a limited exam to diagnose the source of pain and/or infection and recommend treatment alternatives. Payment in full for this limited exam and necessary x-rays must be made *prior* to services being rendered. Patients of record at Bay Colony Dentistry are expected to pay when services are rendered.

After hours and weekends, all calls to our 757-321-1300 phone number are forwarded to the doctor's on call cell phone. If your call is not answered immediately, please leave a message with your name and phone number. Most calls are returned within the hour. Calls after 10 PM will be returned the next morning after 7 AM. Emergency care after normal office hours is available; however, patients will be charged a $200 fee in addition to the normal fees for the services provided. Patients may seek emergency care at their local hospital.

PAST DUE ACCOUNTS

Insurance claims are submitted promptly and most insurance companies pay within 30 days of receiving an electronic claim. If insurance payments are not received within 30 days, then patients will be billed the balance. A 1.5% monthly service charge will be added to any account balance that is remaining after 30 days. Accounts not paid by the due date will be billed and a $5.00 rebilling fee applied to the account balance. Accounts 60 days past due will be turned over to a collection agency. You are responsible for all collection fees (55% of balance) and 100% of all legal fees.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party Relationship to Patient Date

Patient Information

Last Name_____First Name _____ MI _____

Address _____
(Street) (City, State, Zip Code))

Home # (____)_____-_____ Work # (____)_____-_____ Cell/Pager # (____)_____-_____

Birth Date ____/____/____ Age _____ Sex F M Soc. Sec. # _____-_____-_____

Circle One: Single Married Divorced Widowed Email : see medical history form

Employer Name and Address _____Phone:_____
Job Title/Occupation_____ Date Started _____

Name of closest relative not living with you _____
Relative's Address _____
(Street) (City, State, Zip Code)

Relationship _____ Home # (____)_____-_____ Cell Phone# (____)_____-_____

Spouse Information

Last Name_____First Name _____ MI _____

Address (if different):_____
(Street) (City, State, Zip Code)

Home # (____)_____-_____ Work # (____)_____-_____ Cell/Pager # (____)_____-_____

Birth Date ____/____/____ Age _____ Sex F M Soc. Sec. # _____-_____-_____

Email :_____

Employer Name and Address _____Phone:_____
Job Title/Occupation_____ Date Started _____

Insurance Information

Name of Insured _____
Employee SSN _____-_____-_____ Birth Date ____/____/____ Relationship _____
Insurance Company Name & Address _____
_____
Insurance Company Phone # _____Policy/ Group # _____
Secondary Insurance Name of Insured _____
Employee SSN _____-_____-_____ Birth Date ____/____/____ Relationship _____
Insurance Company Name & Address _____
_____
Insurance Company Phone # _____ Policy/Group # _____

Additional Information

How did you find out about our office? _____
What is the reason for your visit with us today? _____
Is there anything about your smile that you would like to improve? _____

Patient Signature _____ Print Name _____
Responsible Party _____ Relationship _____

Health History Form

American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications?_____			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:_____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:_____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:_____			
Recurrent Infections	☐	☐	☐
Type of infection:_____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

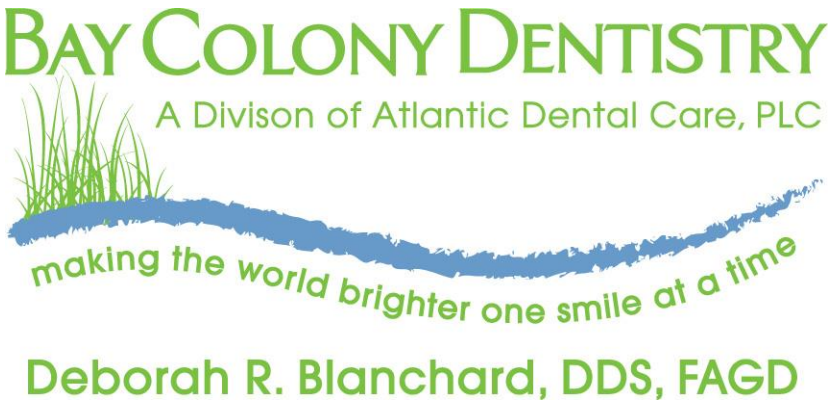
Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: | Date:

FOR COMPLETION BY DENTIST

Comments:_____



Dear Patient,

We are pleased to announce that we have joined together with a group of other local dentists to form Atlantic Dental Care, PLC effective January 1, 2013. Your care will continue to be provided at this office location by your dentist.

In order for us to use your existing records we will need to transfer your records to our new legal entity, Atlantic Dental Care, PLC. The physical location of your records will not change. Your records will remain in our office which is a division of Atlantic Dental Care, PLC. This transfer is a title transfer only.

Please review the Authorization Form below and sign indicating your authorization for us to transfer your records to Atlantic Dental Care, PLC.

If you do not wish for your records to be transferred please do not sign this notice.

We are grateful to you for your continued trust and confidence in us.

Thank you,

Deborah R. Blanchard, DDS, FAGD

Authorization Form

I authorize transfer of my records to Atlantic Dental Care, PLC. I understand that I may choose by signing a written authorization form to have my records transferred to another provider of my choice. If such an authorization is provided to us, we will transfer your records or copies to you or your designee within a reasonable time, and will charge the costs of copying, mailing or delivery of the records.

_____ _____

Signature Authorizing Transfer Date

BAY COLONY DENTISTRY, A DIVISION OF ATLANTIC DENTAL CARE, PLC

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "Protected Health information (PHI)" under a federal health privacy law, as described below:

Specific Description of the information to be Used or Disclosed including the Date of Service(s): Complete transfer of my medical record, all dates of service.

Person(s) or Class of Persons Authorized to make the requested Use of Disclosure: Atlantic Dental Care, PLC

Person(s) or Class of Persons to Whom the Use or Disclosure May be made: Atlantic Dental Care, PLC

Purpose description of the requested us or disclosure: Complete transfer of all records for continuing treatment. This authorization does not expire.

I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke this authorization at any time by notifying the above-named practice I authorized in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken before receiving my revocation. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment and enrollment in a health plan, or eligibility for benefits.

Name of Patient: _____

Signature of Patient: _____ Date: _____

Patient's Date of Birth: _____ Social Security Number: _____

<u>For Personal Representative of the Patient</u>

Name of Personal Representative: _____
Describe Personal Representative Authority: _____
(parent, guardian, etc.)
Signature of Personal Representative: _____
Date: _____

Witness Signature: _____
Name of Witness: _____ Date: _____

Consent to Use of Electronic Mail

Bay Colony Dentistry wants to communicate with patients and other healthcare providers through electronic mail (email). Sending private patient information by email, however, has a number of risks that you should think about:

*Email will be instantly sent worldwide and be received by many intended and unintended recipients.
*Those that get email can pass on messages to anyone without the original sender's permission or knowledge.
*Users can easily misaddress an email.
*Backup copies of email may exist even after the sender or the recipient has erased their copy. Some mails may be kept in your medical record. This means that people who have access to the medical record will be able to see the emails.
*You should not use your employer's email system to send or receive private medical information. If you choose to send or receive an email from your workplace, there is a chance your employer could read the message.
*Email messages may not be answered on the same business day. We will make an effort to read and respond to email as soon as possible, but we cannot guarantee that any email message will be answered within any set period of time.

Bay Colony Dentistry will make every effort to protect the privacy of email information. All of our employees must use password-protected screen savers while working in the office. However, due to the possibility of technical problems, we cannot guarantee the security of all emails. **Your use of email is an acknowledgement of this insecurity and your acceptance of the risk.**

Do not send financial information, credit card numbers, checking account numbers, or any similar information to Bay Colony Dentistry by email. **We will not ask you for this information by email. Any email supposedly from Bay Colony Dentistry asking for credit card or checking account information by email is fraudulent. Please contact the office immediately if such email is received.**

It is your duty to protect your password or other means of access to email sent or received from Bay Colony Dentistry. Bay Colony Dentistry is not responsible for breaches of confidentiality caused by the patient.

Bay Colony Dentistry has permission to send emails to the following address:

_____
Email Address (please print)

_____
Signature of Patient or Responsible Party

_____
Time and Date

Publicity Waiver and Release

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, , as" Bay Colony Dentistry: A Division of ADC" and the undersigned (" I" or " me") agree as follows:

I hereby irrevocably permit, authorize, and license to Bay Colony Dentistry: A Division of ADC and its affiliates, successors, assigns, and licensees to publicly perform and display, transmit, broadcast, reproduce, record, photograph, digitize, modify, alter, edit, adapt, create derivative works, exploit, sell, rent, license, and otherwise use photographs or videos of me (the Materials"), taken on the date indicated below, including the likeness (es) of me, with or without other persons, that are included in the Materials, whether in composite or distorted character or form, on Bay Colony Dentistry : A Division of ADC's social media pages, including , but not limited to, on Facebook, Google+, Instagram, and Twitter, for any lawful purpose whatsoever. Bay Colony Dentistry : A division of ADC also has the right, but not the obligation, to use my name in connection with the Materials, I waive any right I may have to inspect or approve the Materials or any item containing the Materials.

I hereby waive, release, and discharge Bay Colony Dentistry: A Division of ADC from any and all claims and demands arising out of or in connection with the use of the Materials (including the likeness (es) and / or name of me), including without limitation any and all claims for libel, defamation, invasion of privacy, publicity, or personality or similar matter, infringement of "moral rights", all rights under common law, the Copyright Act, and any and all claims for royalties or compensation other than as may be expressly provided in a written agreement between Bay Colony Dentistry : A Division of ADC and myself.

Consent given to : Bay Colony Dentistry : A Division of ADC :
Name_____ Date:_____

Signature: _____

BAY COLONY DENTISTRY

A Divison of Atlantic Dental Care, PLC

making the world brighter one smile at a time

Deborah R. Blanchard, DDS, FAGD

RECEIPT OF NOTICE OF PRIVACY PRACTICES

ATLANTIC DENTAL CARE, PLC

"You May Refuse to Sign This Acknowledgement"

I have been given a copy of this practice's Notice of Patient Privacy Practices and hereby give my consent to the practice's use and disclosure of my protected health information to provide treatment, payment and health care operations.

(Patient Name) (Patient/Parent Signature) (Date)

I give permission for BAY COLONY DENTISTRY, A DIVISION OF ATLANTIC DENTAL CARE, PLC staff to contact the following individuals to discuss treatment and payment options:

(Name) (Relationship to Patient) (Phone/Cell)

(Patient/Parent Signature) (Date)

Practice Purposes Only

Our practice attempted to obtain written statement for Notice of Privacy Practices. Receipt could not be obtained for the following reason:

- o Patient refused to sign notice
- o An emergency occurred and prevented us from obtaining the patient's signature
- o Other (Please specify):

_____

_____

(Staff signature)