I want to thank you for choosing my practice for your dental needs and I am looking forward to meeting you personally. Enclosed you will find various forms that need your attention prior to your arrival at our office. Please take time to fill these out completely. The “Registration”, “Medical History”, “HIPAA Acknowledgement” and “Medications” forms need to be filled out and/or signed and brought with you to your first appointment. Our financial policy and HIPPA information is for your information.

At your “Records Appointment”, we set aside approximately one hour to allow me to examine you and obtain complete records necessary for a thorough evaluation of your dental needs. Any concerns you have or we find will be discussed as well as options for treatment to help keep you in the best of dental health. Upon completion of this appointment, we have you scheduled with one of our hygienists for a dental prophylaxis cleaning. You should plan on being with us for about two hours. Since each patient has specific dental concerns, we take these steps to insure that we are treating each patient on an individual and personal basis for optimal care.

Once again, thank you for choosing my practice for your dental care. If you have any questions, please feel free to contact our office at (704) 708-4201.

Sincerely,

C. Scott Davenport, D.D.S.
PATIENT’S NAME ________________________________ CALLED ______________________________

First  Middle  Last

IF CHILD: PARENT’S NAME ________________________________________________________________

First  Middle  Last

HOME ADDRESS _________________________________________________________________________

Street  City  State  Zip

HOME PHONE (_____)______-_______  OFFICE PHONE (_____)______-_________

EMAIL ADDRESS _______________________________________  CELL PHONE (_____)______-_______

DATE OF BIRTH _____/_____/_____  SOC. SEC. NO. _______-______-_______

MARITAL STATUS _______________  MALE / FEMALE

EMPLOYER _____________________________________  OCCUPATION __________________________

BUSINESS ADDRESS _______________________________________________________________________

Street  City  State  Zip

SPOUSE ___________________________________________________  PATIENT HERE? yes  no

First  Middle  Last

SPOUSE’S EMPLOYER ________________________________________  PHONE (_____)______-_______

EMERGENCY CONTACT: ______________________________________  PHONE (_____)______-_______

WHO MAY WE THANK FOR REFERRING YOU?_____________________________________________

MAY WE SEND THEM A THANK YOU CARD FOR REFERRING YOU? YES  NO

DENTAL INSURANCE:

Ins. Company _______________________________________________

Address: _________________________________________________

Phone No: ________________________________________________

Group Name: ______________________________________________

Group Number: ____________________________________________

Policyholder: ______________________________________________

Date of birth: ______________________________________________

Soc. Sec. No.: _____________________________________________

I acknowledge that the above information is true, to the best of my knowledge. I authorize the release of any information regarding my past, present or future health care, that may influence my dental care, to and from Dr. Davenport and/or his representatives. I authorize Dr. Davenport and/or his representatives to contact my insurance carrier regarding my insurance coverage and the filing of claims. I have received and read this office’s policy on payment for services rendered (“Financial Policy”) understand it fully. I understand that I am fully responsible for all charges incurred during treatment, regardless of insurance coverage.

SIGNATURE_______________________________________________  DATE____________________

(Parent or Guardian, if patient is under 18 years old)
MEDICAL HISTORY

1. Have you ever been seriously ill? YES NO
2. Have you ever been hospitalized? YES NO
3. Have you been examined by a physician within the last year? YES NO
   Physician's name _________________________ Phone ________________
4. Have you taken any drugs or medications in the last year? YES NO
5. Are you allergic to any medications or substances? YES NO
6. Check any of the following that you have or have had:
   [ ] Heart problems          [ ] Emphysema            [ ] A.I.D.S or HIV positive
   [ ] High blood pressure     [ ] Tuberculosis (TB)    [ ] Hepatitis A (infectious)
   [ ] Heart murmur            [ ] Asthma               [ ] Hepatitis B (serum)
   [ ] Chest pains (Angina)    [ ] Sinus trouble       [ ] Hepatitis C
   [ ] Rheumatic fever         [ ] Allergies or Hives  [ ] Liver disease
   [ ] Artificial joints       [ ] Diabetes            [ ] Bruise easily
   [ ] Anemia                  [ ] Thyroid disease     [ ] Drug addiction
   [ ] Stroke                  [ ] Venereal disease     [ ] Hemophilia
   [ ] Kidney trouble          [ ] Chemotherapy        [ ] X-ray or cobalt therapy
   [ ] Ulcers                  [ ] Arthritis           [ ] Cold sores
   [ ] Epilepsy                [ ] Seizures            [ ] Pain in jaw joints
   [ ] Fainting                [ ] Dizzy spells         [ ] Psychiatric treatment

7. Are you aware of any weight change in recent months? YES NO
8. Do you find yourself short of breath after mild exertion? YES NO
9. Do you have frequent or severe headaches? YES NO
10. Are you subject to frequent urination? YES NO
11. Are you often thirsty? YES NO
12. Do you smoke? YES NO
13. Are you aware of any medical condition not mentioned above? YES NO

FOR WOMEN ONLY:
Are you pregnant? [ ] YES [ ] NO If yes, what month? ____________
Are you taking birth control pills? YES NO

DENTAL HISTORY

1. Who was your former dentist? Name _________________________ City _________________________
2. Frequency of care: [ ] Semiannual [ ] Annual [ ] Irregular [ ] Emergency only
3. How would describe your present dental health? [ ] GOOD [ ] FAIR [ ] POOR
4. How often do you brush your teeth? ____________________
5. How often do you floss your teeth? ____________________
6. Are you having pain or discomfort at this time? YES NO
7. Do you have discomfort with the jaw joints? YES NO
8. Do you experience neck aches, tender jaw muscles, or limited oral opening? YES NO
9. Do you grind your teeth? YES NO
10. Do your gums bleed when you brush? YES NO
11. Check any of the following specialists you have seen:
   [ ] Periodontist (gums) [ ] Orthodontist [ ] Endodontist (root canal)
12. How do you feel about losing your teeth?
   [ ] Never, if possible [ ] No feeling [ ] You're suppose to [ ] Better without them

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE AND COMPLETE.

SIGNATURE ___________________________________________ DATE __________________

MED / DENT HISTORY
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FINANCIAL POLICY

In order to continue to provide quality dental care and keep our fees at a reasonable level, we have adopted this financial policy.

All fees totaling less than $200.00, we ask that you pay that amount, in full, on the day of service. For fees totaling $200.00 or more, we offer three options of payment:

(1) Cash or check for the full amount the day the services are begun. In return, you will receive a bookkeeping adjustment for 5% of the total fee. For example, if your fee is $200.00, you will receive $10.00 credit, if you pay in full by cash or check.

(2) Payment by credit card for the full amount the day the services are begun. Because we are charged a fee for processing credit card payments, we are unable offer a bookkeeping adjustment.

(3) One-half the total fee the day services are begun and one-half the day the services are completed.

In addition to cash or check payments, we accept MasterCard, Visa. All fees are the responsibility of the patient. There will be absolutely no interest charged on balances that are paid within 60 days. After 60 days, there will be a finance charge of 18% APR (1.5% monthly).

MANAGED DENTAL CARE PROGRAMS

Dr. Davenport is not a participant in any managed care programs due to the restrictive nature of these programs. He feels that all dental treatment should be the decision of the doctor and patient only.

FOR PATIENTS WITH CONVENTIONAL DENTAL INSURANCE

We will gladly estimate your insurance benefit and your co-payment. For co-payments less than $200.00, we ask that you pay that estimated amount, in full, the day the service is begun. When estimated patient copayments are $200.00 or more, payments should be handled as previously outlined in this policy. We will adjust your account, if necessary, after insurance payment is received.

WE ARE HAPPY TO FILE PRIMARY INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS. HOWEVER, IT IS THE PATIENT'S RESPONSIBILITY TO BE AWARE OF ALL TERMS OF THEIR INSURANCE COVERAGE, CURRENT STATUS OF THEIR INSURANCE BENEFITS AND FOR ANY FOLLOW-UP ON INSURANCE FILED BY OUR OFFICE. ALL FEES ARE THE RESPONSIBILITY OF THE PATIENT, REGARDLESS OF INSURANCE COVERAGE.

For those with secondary dental insurance, we will provide you with the information needed for you to file that claim. We will estimate the amount of your primary insurance and ask that you pay the remainder the day of service, or as outlined previously.

*Our main concern in this office is to render the best quality dental care available. We understand that on occasion there is need for financing outside of our normal financial policy. For those patients needing this courtesy, please ask one of the business assistants for more information.