Thousand Oaks Gentle Dentistry
Chris Whetstone, DDS, Inc.

Dear New Patient,

Welcome to the office of Dr. Chris Whetstone and thank you for choosing us for all your general dental needs.

Dr. Whetstone attended UCLA for her undergraduate degree, continuing on there to earn her Doctor of Dental Surgery degree from the UCLA School of Dentistry in 1985. She has been in practice at her present location since August 1, 1988. The office is located one block east of Moorpark Road in the 4-story Sinclair Building at 223 E. Thousand Oaks Boulevard suite #316.

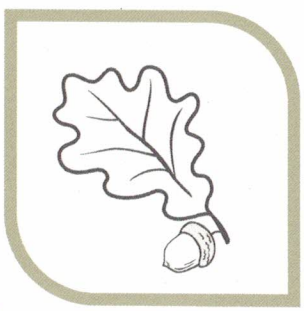
Regarding billing, payment is expected at the time of service, unless you subscribe to an accepted insurance plan. In that case, you must provide us with current insurance information at each visit. A copy of your dental insurance card would be appreciated. We will submit the insurance claim for you and notify you of any balance due.

Please be aware that there are many different types of insurance coverage these days. Although we will certainly try to clarify any billing questions that may arise, we ask that you maintain a thorough understanding of your own particular dental plan, including such things as annual maximums, deductibles and percent coverage. If you are ever in doubt as to whether a procedure will be covered by your insurance, we encourage you to request a pre-authorization.

Again, we welcome you to our office and we hope that our relationship will be a long and healthful one.

Sincerely,

Dr. Chris Whetstone and Staff



223 Thousand Oaks Blvd #316
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chriswhetstonedds.com

Welcome to Thousand Oaks Gentle Dentistry
Patient Information

Date: _____

Name_____ Prefer to be called_____

Male____ Female____ Marital Status: Single_____ Married_____ Widowed_____ Divorced_____

Address: _____
Street City/State Zip

Date of Birth_____ Social Security #_____

Occupation_____ Employer_____

Home Phone_____ Cell Phone_____ Business Phone _____

Email address_____

Emergency Contact_____ Phone_____

How did you hear about our office? _____

Spouse's name_____ Date of Birth_____

Spouse's occupation_____Employer_____

If patient is under 18, name of parent/guardian_____

If patient is a student, name of school/college_____

_____

DENTAL INSURANCE INFORMATION

Primary Insurance _____

ID#_____Group#_____

Subscriber's name_____ Subscriber's SS# _____ DOB _____

Patient's relationship to Subscriber: Self_____ Spouse _____ Child _____

Secondary Ins_____ ID#_____ Group# _____

Subscriber's Name _____ Subscriber's SS# _____ DOB_____

Patient's relationship to subscriber: Self_____ Spouse_____ Child_____

I authorize the release of any information necessary to process my insurance claim.

Signature_____ Date _____

I hereby authorize payment to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original.

Signature_____ Date _____

Medical History

Name_____ Sex____ Birthdate_____ Date_____

An accurate and complete medical history is required so that we may provide the best dental care possible. For your protection, please answer all questions completely and advise us of any changes in your health history before each visit.

1. Have you been examined by a physician in the past year? Yes No
2. Are you sensitive or allergic to any medications?

Penicillin	Yes	No	"Novocain"	Yes	No
Erythromycin	Yes	No	Aspirin	Yes	No
Tetracycline	Yes	No	Anesthetics	Yes	No
Codeine	Yes	No	Latex	Yes	No

Other_____

3. Have you ever experienced excessive bleeding following a cut, extraction, or surgery? Y N
4. Do you have or have you ever had?

Heart murmur	Yes	No	Artificial heart valve	Yes	No
Rheumatic fever	Yes	No	Any artificial joints	Yes	No
Heart attack	Yes	No	Angina (chest pain)	Yes	No
High blood pressure	Yes	No	Other_____		

5. Has your physician ever recommended pre-medication before a dental appointment? Y N
6. Do you have or have you ever had:

Stroke	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	Liver disease	Yes	No
AIDS/HIV	Yes	No	Dizzy spells	Yes	No
Diabetes	Yes	No	Swollen ankles	Yes	No
Epilepsy	Yes	No	Tuberculosis	Yes	No

Other serious illness_____

7. Please list all hospitalizations:_____
8. Please list all prescription and non-prescription drugs taken during the past 3 months:

_____

_____

9. Have you been told you snore or stop breathing at night? Yes No
10. Do you smoke or use any tobacco? Yes No
11. Do you drink alcohol? Yes No Frequency_____
12. Women.....are you pregnant? Yes No
13. Do any teeth hurt? Yes No
14. Do your gums bleed? Yes No
15. Do you clench or grind your teeth? Yes No
16. Date of last dental examination:_____

For Office Use Only

Reviewed by:_____ Date:_____ Reviewed by:_____ Date:_____

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Chris Whetstone, D.D.S. Inc.
223 E. Thousand Oaks Blvd., Suite 310
Thousand Oaks, CA 91360

CONSENT FOR DENTISTRY

This is my consent for Chris Whetstone, D.D.S. and designated associates to perform any dental procedures deemed necessary and/or advisable. I agree to the use of local anesthetic and analgesic as recommended by the dentist involved in my care. I understand that occasionally there are complications associated with dentistry, drugs and anesthesia, including but not limited to:

1. Pain and swelling, infection and post-operative hemorrhage.
2. Facial muscle stiffness and jaw soreness.
3. Exacerbation of localized oral lesions such as canker sores or cold sores.
4. Anesthetic complications such as abnormal or allergic reactions to drugs or in rare instances, cardiovascular collapse.
5. Unfavorable postoperative reactions such as nausea, allergic reactions or minor discomfort.

I understand that there is no warranty or guarantee as to any result or care. I will ask for a full recital and explanation of all possible risks associated with my dental procedures if I have any questions or concerns.

Patient/Guardian Signature:_____ **Date:**_____

FINANCIAL RESPONSIBILITY

Patients without dental insurance may settle their accounts by:

1. Paying in full at time of treatment. We accept Visa MasterCard, American Express, personal checks and, of course, cash. For your convenience you may call in credit cards by phone.
2. For major dental work we are happy to offer our patients a three month payment plan option. A patient may split their balance in three equal payments with the first payment being due at the start of the treatment and the next two payments being due on the first business day of the following two months. If payments are made on time we will waive the monthly billing fee. If payments are not being made as agreed upon a monthly service fee will apply. Our monthly fee is $5.00 per month for each patient account with a balance up to $200.00, for balances that exceed $200.00 the monthly billing fee will be $10.00 per month applied on the first of each month until your balance is paid in full. This fee is non-negotiable. All delinquent accounts will be referred to an outside collection agency for recovery if not paid in full by the end of the 3rd month.

Patients with dental insurance may settle their accounts by:

1. As a courtesy for our patients with dental insurance, our office will do all the necessary paperwork for your claim and submit it to the insurance company provided to us. We will do our very best to work with your insurance company to get your claim paid but if the claim is not paid in a timely manner or is denied due to your plan benefits the patient will be held fully responsible for all unpaid balances. If the account is not paid after the first billing statement the account will be subject to a

repeat monthly billing fee of $5 or $10 as stated in the Financial Responsibility section 2 above, unless other payment arrangements are made in advance.

2. ***Be advised that our office no longer places amalgam (silver) fillings which contain mercury. Your insurance may not cover the cost difference between an amalgam filling and a white composite filling. This cost difference is the patient responsibility.***

CANCELLATION/MISSED APPOINTMENT POLICY

We understand that our patients lead busy lives and sometimes are not able to keep appointments. However, we reserve Dr. Whetstone's and/or our hygienist's time when we make your appointment. A broken appointment or a cancellation with less than 24 hours notice is a loss to 3 people-the patient that missed the valuable time, the patient that could have used the valuable time and the dentist that was fully staffed and prepared for your visit; therefore, we charge a fee of $50.00-$-100.00 depending upon the procedure scheduled. This fee cannot be charged to your insurance company and is due upon receipt. If you fail to call us with 24 hours notice we will try to fill the appointment and if we are successful we will not charge for the missed appointment. If we are unable to fill it then our missed appointment policy will apply. We also understand emergencies do arise, in the event of an emergency the missed appointment/late cancel fee will be waived for the first occurrence only.

I understand that I am responsible for any and all charges not paid by an insurance company for whatever reason.

Patient/Guardian Signature:_____ **Date:** _____

CONSENT FOR EMAIL COMMUNICATION

I give my consent for Dr. Whetstone & staff to contact me by email for such things as reminders for dental cleanings, outstanding treatment plans, personal diagnosis, appointment reminders and general office information.

Patient/Guardian Signature:_____ **Date:**_____

Email Address_____

PRIVACY PRACTICES ACKNOWLEDGEMENT & DENTAL MATERIALS FACT SHEET

I have received the Notice of Privacy Practices and Dental Materials Fact Sheet and I have been provided an opportunity to review them.

Patient/Guardian signature:_____ **Date:**_____