DAVID KAHN DMD | MATTHEW KAHN DDS

159 ROUTE 25A, SUITE 1C, MILLER PLACE, NY 11765 | 631-509-4486

I certify that I have read and understand the questions asked in this health history form. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my doctor, or any other member of LI Sound Dental Solutions, responsible for any errors or omissions that I have made in the completion of this form

X ______________________________ X ________ X ______________________________ X ________
Signature of patient (guardian if minor) Date Doctor's signature Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X ____ X ________________
Signature of patient (guardian if minor) Date

If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors, insurance carriers, or any doctors to whom LI Sound Dental Solutions might refer treatment. I understand that I have the right to request restrictions on how my protected health information is used and disclosed, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

X ____ X ________________
Signature of patient (guardian if minor) Date

I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is my responsibility as the patient to pay any deductible amount, co-insurance or any other balance not paid for by my insurance company. I understand that I will be responsible for all collections costs, attorney fees and court costs.

X ____ X ________________
Signature of patient (guardian if minor) Date

I have been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

X ____ X ________________
Signature of patient (guardian if minor) Date

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GENERAL CONSENT TO TREAT

I, ________________________, consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography (x-rays and CBCT).

I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.

I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.

My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.

I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

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Patient or Guardian Printed Signature Date

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Doctor Printed Signature Date