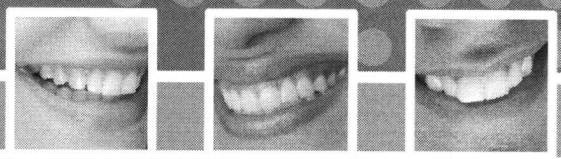
Kirk N. Hampton, D.D.S.
10995 Plano Rd. Suite 102
Dallas TX 75238

(214)553-8303

staff@hamptondds.com
www.hamptondds.com



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

◯ Dental Office ◯ Yellow Pages ◯ Internet/Website
◯ Newspaper ◯ School/Work ◯ TV Advertisement
◯ Insurance Provider Directory ◯ Other

Name of person, office, or other source referring you to our practice:

_____

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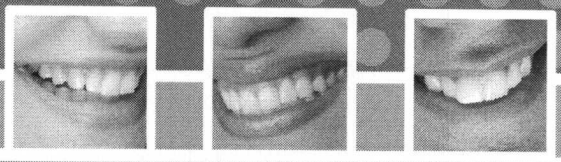

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ (City) ____ (State) _____ (Zip Code)

Please provide the receptionist with your drivers license or ID - so that we can make a copy for your file

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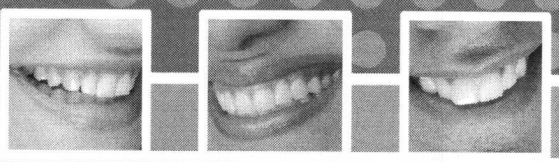

Medical History

Have you ever had any of the following? Please check those that apply:

- ☐ *Pre-Med - Amox
- ☐ Allergy-Amoxicillian
- ☐ Allergy-Erythro
- ☐ Allergy-Other_____
- ☐ Allergy-Sulfa
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Pressure-Low
- ☐ Dizziness
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Rheumatism
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ *Pre-Med - Clind
- ☐ Allergy-Aspirin
- ☐ Allergy-Ibuprophen
- ☐ Allergy-Penicillin
- ☐ Allergy-Tylenol
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Cancer _____
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ HIV
- ☐ Liver Disease
- ☐ Other-See Notes
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Tobacco-Smoke
- ☐ Tumors
- ☐ *Pre-Med - Other____
- ☐ Allergy-Codeine
- ☐ Allergy-Latex
- ☐ Allergy-Seasonal
- ☐ Alzheimer's
- ☐ Artificial Joints
- ☐ Blood Pressure-High
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Tobacco-Smokeless
- ☐ Ulcers

Notes and/or clarification:

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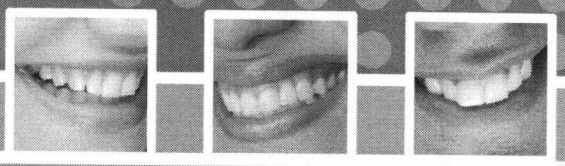

Medical History (cont)

Have you ever had a complication or reaction to dental anesthetics? Yes / No Please describe.

Please list ALL drugs and medications you are currently taking (BOTH prescription & non-prescription)

Are you currently under the care of a physician? Yes / No
If "Yes" please list Name(s) and phone number(s).

Do you have any health problems that need further clarification? Yes / No
If "Yes" please explain.

Do you currently have or have any history of a chemical dependency? Please explain.

When was your last dental exam/visit? Who was the attending doctor (dentist)/office?

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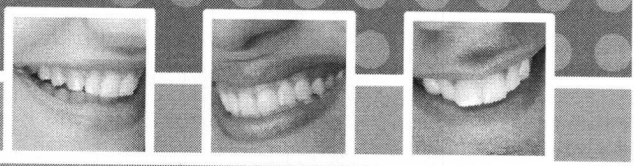

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Please provide the receptionist with insurance card - so that we can make a copy for your file

Please note that a completed form for credit card/debit card authorization is required for insurance filing. This form is located on page 7

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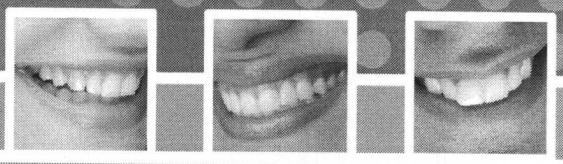

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Please provide the receptionist with your insurance card - so that we can make a copy for your file

Please note that a completed form for credit card/debit card authorization is required for insurance filing. This form is located on page 7

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Insurance Filing Service Agreement
Credit Card/Debit Card Authorization

In order to provide the highest level of service we ask that you authorize us to pay balances of less than $100.00 (One Hundred Dollars & 00 Cents), per service date, automatically to your payment method of record following the completion of filing and collections as determined to be complete by our office.

PLEASE CHOOSE ONE OF THE FOLLOWING:

◯ I authorize automatic credit/debit card authorization.

The patient prefers and our office agrees to file and accept assignment of the patient's insurance benefits. I authorized the office of Kirk N. Hampton DDS to debit my selected payment method for any fees not collected from insurance under the amout of $100.00.

◯ Mastercard ◯ Visa ◯ Amex ◯ Bank Debit Card

Card #_____ exp date_____
zip code associated with card_____
A copy of your card (front and back) is required to keep on file.

Signature: _____ Date: _____

◯ I decline automatic credit/debit card authorizations.

I, the patient/responsible party, prefer not to have a card kept on file. I, the patient/responsible party, prefers to accept assignment of benefits directly from my insurance company and agrees to pay for services in full at date of service unless otherwise agreed upon with a personal financial arrangement made directly with the practice.

Signature: _____ Date: _____

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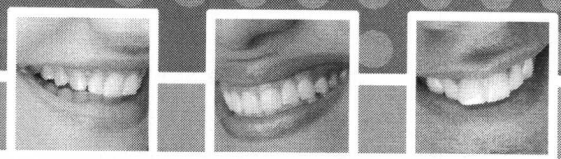

Financial Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without written & signed financial arrangements, must be paid for in cash at the time services are performed.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of sixty days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder for any breach or failure to comply with the terrms of this or other related financial agreements as executed and agreed.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kyle Hampton
Telephone: 214-553-8303
E-mail: staff@hamptondds.com
Address: 10995 Plano Rd, Suite 102, Dallas, TX 75238

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will NOT affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you and/or continue treating you if you revoke this consent.

Consent - I have had full opportunity to read and consider the contents of this content form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

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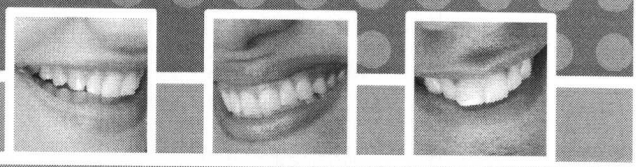

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 requires that health care providers provide a copy for the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of same.

By signing this form I comfirm that I have received a copy of the office Notice of Privacy Practices.

Signature: _____ Date: _____

Pages 11 - 14 are for you the patient to keep

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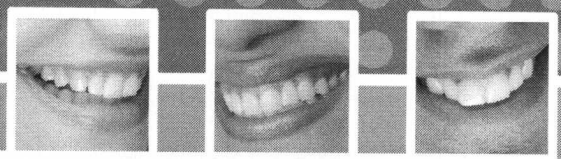


Kirk N. Hampton DDS
Notice of Privacy Practices

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will be effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

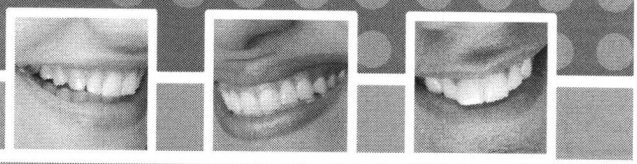
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.



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 officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, e-mail, text messaging, etc...).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies (i.e.. digital files). We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25 plus reproduction cost for radiographs and other diagnostic images, $50 per hour for staff time, if you request information older than 5 years, to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summery or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.)

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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.

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

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 you disagree with a decision we made about access to your health information or in a 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 may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Service 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 US Department of Health and Human Services.

Contact Officer: Kyle Hampton
Telephone: 214-553-8303
Fax: 214-553-8311
E-mail: staff@hamptondds.com
Address: 10995 Plano Rd, Suite 102, Dallas, TX 75238

Response Date: 8/9/2012