Welcome to the Neighborhood, We're glad you chose to visit with us!

It is with greatest pleasure that we welcome you to the office of Dr. Sonya White and the "Bright White Smile Team." Sometimes it's difficult finding health care providers who make you feel comfortable and at ease when discussing your medical needs, so we ask that you allow us to show you how important you are to us.

In our office, you will find the most "dazzling smiles" and the warmest personalities waiting to greet you. We will gladly discuss your dental needs with a professional and courteous attitude.

Dr. White has been in private practice since 1997 and is committed to excellence. She continues her post-graduate training at the prestigious Las Vegas Institute for Advanced Dental Studies in Nevada. By undergoing training, Dr. White consistently achieves the clinical ability that few dentists in the country are even aware exist. She is one of the few LVI dentists in the area.

With two locations to conveniently serve you, appointments are available in Moss Point, MS and Mobile, AL. Monday – Thursday from 8:30am to 4:00pm. We accept most dental insurance policies and our competent office administrator will be happy to assist you in maximizing your insurance benefits. We also offer, the White Smile Plan, Tower Loans, CareCredit to help you get the "perfect" smile.

Call our offices today to schedule a reservation. We are located in Piccadilly Square at Airport and Hillcrest and our phone number in Mobile is (251)341.1500. The Moss Point office is located at 4014 Main Street in the State Farm Building, our number is 228.474.7645.

Dr. Sonya White, DDS and the White Smile Team

Mission Statement of Dr. Sonya White, DDS
And the "Bright White Smile Team"

Our goal and policy is to provide our patients with the highest quality of dentistry available. We strive to be the best and treat our patients as one of our own family members.

We have genuine concerns for your comfort before, during and after your treatment. Our team is passionate about helping you achieve your goals. Being of service to our patients is the definition of our purpose and the mission of our practice.

To accomplish our mission, we will provide:

As a result of these provisions, we hope that:

- A highly trained and professional staff.
- State-of-the-art equipment and technology.
- A genuine concern for our patient's time.
- Our patients will be highly satisfied with their personalized care.
- They will continue as a part of our practice family.
- They will enjoy oral health and beautiful smiles for a lifetime.
- Our patients will feel a desire to refer their friends and family.
- Our patients will uphold their scheduling and financial commitments.

WE PLEDGE AND GUARANTEE THAT WE WILL ALWAYS DO OUR VERY BEST TO SERVE YOU.

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How often do you floss? _____		
			Lip or cheek biting	☐ Yes	☐ No			
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

5 HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		
Do you wear contact lenses?	☐ Yes ☐ No				

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Practice Limited To General Dentistry
NOTICE OF PRIVACY PRACTICES

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 the Notice while it is in effect. This Notice takes effect April 3, 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 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 to services we provided to you.

Healthcare Operations: We may use and disclose your healthcare 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, and 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 disclosures permitted by your authorization while it was in effect. Unless you give us a written authorizations, we cannot use or disclose your health information for any reason except those described in the 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 family members, 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 your 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, or 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 of 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 my law.

Abuse or Neglect. We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence of 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 authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official 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, or letters).

PATIENTS 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. WE will use the format you request unless we cannot practicably 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 $0.25 for each page, $22.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary 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 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 are 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 or disclosure of your health information. We are not required to agree to these additional restrictions but if we do, we will about by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about health information by alternative means or to alternative locations (You must make your request in writing). Your request must specify that alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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 Website or by electronic mail (email), 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 response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with us 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 U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Resources.

Contact Office: Dr. Charles Dent

Telephone: 228.474.7645 Fax: 228.474.6406

Email: officemanager@whitesmilecenter.org

Address: 4014 Main Street, Moss Point, MS 39563

Extensive Detailed Examinations

Dear New Patient,

First, let me begin by explaining the definition of dentistry. Dentistry is the science and art of preventing, diagnosing and treating diseases, injuries and malformations of the teeth, jaws and mouth."

All of my patients will be made aware that an inspection of their periodontal tissues, both hard and soft, is a normal part of a dental examination. A detailed and extensive oral examination allows me to determine if a patient is a risk of periodontal diseases, oral cancer or if they have cavities.

It is my responsibility to ensure that you are informed of the periodontal diagnosis, the need for treatment, the anticipated benefits of the treatment proposed, the possible complications of the treatment proposed, the consequences of non-treatment and to address of your dental needs.

With all the new information linking periodontal disease with systemic diseases, such as diabetes, lung and respiratory diseases, pre-term low birth weight babies, weakened immune systems, osteoporosis and gastric ulcer, it is not just about teeth anymore.

It is a policy of this practice to always do a detailed examination for new patients, including x-rays; develop a diagnosis and a treatment plan, perform an oral cancer screening, inform patients and document all clinical findings including conversations with you, our patient.

Now that I have clarified my position on why I perform detailed examinations, I hope that you will check the yes box below. The cost of this examination is $301.00.

Dr. Sonya White, DDS, PC

_____ Yes, I accept the detailed extensive examination and I am aware that I am responsible for any cost that is not covered by my insurance policy.

_____ No, I do not accepted the detailed extensive examinations, it is not covered by my insurance plan. I understand the need to have this examination based on the information I've read above, however, I refuse.

Dr. Sonya White, DDS

6309 Piccadilly Square Drive
Mobile, AL 36609-5103
(251)341-1500

Written Financial Policy

Thank you for choosing Dr. Sonya White, DDS, PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy as possible by offering serval payment options.

Payment Options:

You can choose from:

- ***Cash, Check-Cards, Visa, MasterCard or Discover Card***

We offer a 10% courtesy accounting adjustment to patient who pay for their treatment with cash prior to completion of care for treatment plans of $3000.00 or more

- **Convenient Monthly Payment Plans**; CareCredit or Tower Loan

We allow you to pay monthly with no Annual fees or pre-payment penalties.

Please Note:

Dr. Sonya White, DDS, PC requirements payments prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance sbumissions.

A fee of $35.00 is charged for patients who miss two (2) appointments during the year without a 24-hour notice.

Dr. Sonya White DDS, PC charges $47.00 dollars for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help get the dentistry you want or need.

In the event a collection agency is retained to receive balanced owed, I am aware a 33% of account balance will be added to the total amount due for collection agency fees.

Patient, Parent or Guardian

Signature _____ Date: _____

Patient Name (Please Print): _____

This agreement supersedes all other verbal and or written agreements.

How Did You Hear About Us?

We are pleased that you chose our office to care for your dental needs!

Often, our patients tell us that they have referred their friends and family to us to care. Will you tell us how you heard about us?

Please use the options below that led you to us, and thanks you for choosing the office of Dr. Sonya White and the Bright White Smile Team!

Radio _____
Yellow Pages _____
Internet _____
Newspaper _____
Friends/Family _____
Staff Referral _____
Other _____