

## Patient Registration

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Patient Is:  Policy Holder  Responsible Party  Neither \_\_\_\_\_

### Responsible Party ( if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers License: \_\_\_\_\_

Responsible Party is Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Policy Holder

### Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State/ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers License: \_\_\_\_\_

EMAIL: \_\_\_\_\_ For patient confirmation of appointments and specials

Accepts Text Message: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Employment Status  Full Time  Part Time  Retired

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Student Status:  Full Time  Part Time

### Primary Insurance Information

Name Of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Social Security: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Insured ID number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### Secondary Insurance Information

Name Of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Social Security: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Insured ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

## Tell us about your child age 12 and under

Child's name \_\_\_\_\_

Child's birth date \_\_\_\_\_ Nickname \_\_\_\_\_

School \_\_\_\_\_ Hobbies \_\_\_\_\_

Who is accompanying the child today? \_\_\_\_\_

Relationship to child \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_

Last dental visit? \_\_\_\_\_

Is the child currently in pain? \_\_\_\_\_

Does the child require antibiotics before dental treatment? \_\_\_\_\_

Has the child ever had a serious/difficult problem associated with previous dental work? \_\_\_\_\_

Is the child taking fluoridated supplements? \_\_\_\_\_

Has the child ever had any pain/tenderness in his/her jaw joints? \_\_\_\_\_

Does the child brush his/her teeth daily? \_\_\_\_\_

Floss his/her teeth daily? \_\_\_\_\_

Has he/she been to an orthodontist? \_\_\_\_\_

Child's Physician \_\_\_\_\_

Phone # \_\_\_\_\_ Date of last visit \_\_\_\_\_

Is the child currently under the care of a physician? \_\_\_\_\_

Please describe the child's current physical health. Good \_\_ Fair \_\_ Poor \_\_

Please list current medications child is taking \_\_\_\_\_

List all drug allergies \_\_\_\_\_

Latex allergy Y\_\_N\_\_

Does/ did the child have any of the following habits?

Breast fed Y\_\_ N\_\_

Nursing bottle habits Y\_\_N\_\_

Chewing on objects Y\_\_ N\_\_

Speech problems Y\_\_N\_\_

Clenching/grinding teeth Y\_\_N\_\_

Thumb/finger sucking Y\_\_N\_\_

Lip sucking/biting Y\_\_N\_\_

Tongue/cheek biting Y\_\_N\_\_

Mouth breather Y\_\_N\_\_

Tongue Thrust Y\_\_N\_\_

Nail biting Y\_\_N\_\_

Used pacifier Y\_\_N\_\_

I affirm that the information I have given is correct to the best of my knowledge. It will be held in strictest confidence.

I authorize the dental staff to perform the necessary dental services my child may need.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
date

Michelle B Deutch D.D.S.  
**Eaglesoft Medical History**

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes \_\_\_\_\_

Are you on a special diet?  Yes  No If yes \_\_\_\_\_

Do you smoke or chew tobacco?  Yes  No If yes \_\_\_\_\_

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes \_\_\_\_\_

Do you use controlled substances?  Yes  No If yes \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Seasonal Allergies <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No	Depression <input type="radio"/> Yes <input type="radio"/> No	Premedication <input type="radio"/> Yes <input type="radio"/> No	Anxiety <input type="radio"/> Yes <input type="radio"/> No
Heartburn/Reflux <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed  Yes  No If yes \_\_\_\_\_

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: \_\_\_\_\_

X

Date: \_\_\_\_\_

## **Financial Policy**

Thank you for choosing us as your dental health care provider. We look forward to assisting you in attaining optimum oral health.

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment. All patients must also complete our Patient Information Form as well as your insurance form, if required by your plan, before seeing the doctor.

**Full Payment Is Due At The Time Of Service** unless other financial arrangements have been made in advance. We accept cash, check, Master Card, Visa, and Discover cards. Other financial services are available through Wells Fargo.

A monthly billing fee of 1.5% or \$5.00, whichever is greater, will be added to all accounts that remain unpaid after 60 days. If it becomes necessary to use other means for collecting payment, the patient is responsible for any and all costs, fees, and attorney fees incurred.

### **Regarding Insurance**

Our office requires that you pay your deductible and co-payment, if applicable, at the time of service. While every effort will be made to maximize your insurance benefits, **the balance is your responsibility, whether your insurance company pays or not.** If your insurance company has not paid your claim within 60 days, the balance will be automatically billed to you. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your policy.

We will file insurance claims for you if you bring all insurance information and a completed insurance claim form, if required by your plan. **Information regarding insurance benefits is the responsibility of the patient.** Estimates given by our office are not a guarantee of benefits. We cannot be held responsible for the benefits paid, or not paid, by your insurance company.

### **Emergency Care**

All emergency care patients are expected to remit payment at the end of the appointment.

### **Missed Appointments**

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please have the courtesy to give us at least 48 hours notice so that we may help serve other patients wanting treatment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read this Financial Policy, and understand and agree to this Financial Policy.

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Print Name

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Patient or Responsible Party

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Date

Michelle B. Deutch, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*You May Refuse to Sign This Acknowledgement

I, \_\_\_\_\_, have received a copy of this office's Notice of  
Privacy Practices.

Please Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**For Office Use Only**

We attempt to obtain written acknowledgement of receipt of our Notice of Practices, but  
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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Michelle B. Deutch, D.D.S.

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## 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.

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### 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 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 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 at the end of the notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

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

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider provident 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 health 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 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 judgement 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 reasonable 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 official having lawful custody or 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, emails, or letters).

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## 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. 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 \$.25 for each page, \$3.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you 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 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 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.

**Restrictions:** 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 those 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). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location 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 web site or by electronic mail (email), you are entitled to receive this notice in written form.

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## QUESTION 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 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 also may 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 on 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 U.S. Department of Health and Human Services.

Contact Officer: Sandy Curtis- Office Administrator

Telephone: 913-469-0085 Fax: 913-730-1930

Email: [mbddds@aol.com](mailto:mbddds@aol.com)

Address: 8575 W. 110<sup>th</sup> Street, Suite 326, Overland Park, Ks. 66210

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- This Form is educational only, does not constitute legal advice, and covers only federal, not state law (August 12, 2002).

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Dr. Michelle Deutch to use or disclose my Personal Health Information (PHI) as described below. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI may no longer be protected by federal privacy regulation. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice. It is available upon request.

Patient authorizes communication with family/friends regarding your care and test results.

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relation \_\_\_\_\_

Patient authorizes communication with family/friends regarding your account and billing.

Name \_\_\_\_\_ Phone# \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relation \_\_\_\_\_

Patient authorizes communication with a primary care physician or other physician (first and last name):

1. \_\_\_\_\_ Phone # \_\_\_\_\_

2. \_\_\_\_\_ Phone # \_\_\_\_\_

Best way to contact you regarding messages, responses, appointment reminders etc. (mark all that apply).

Home phone\_\_ Work Phone \_\_ Cell Phone \_\_ Email \_\_

May we leave a message with whomever answers the phone or on voicemail?

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your PHI in reliance on your consent.

May we fax and/or email to other providers if necessary for medical care? Yes No NA

Signature of patient (or patient’s representative) \_\_\_\_\_

Printed legal name of patient (or patient’s representative) \_\_\_\_\_

Date \_\_\_\_\_

**\*\*CREDIT/DEBIT POLICY\*\***

PATIENT NAME \_\_\_\_\_

I understand it is the policy of Michelle Deutch, D.D.S. to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with the provisions of the U.S. law.

If, after a claim has been submitted to my insurance carrier: 1) the claim is denied for any reason: OR 2) there is a patient liability (I.E. Deductible, Co-insurance, etc.) the office will send a statement notifying me of the balance. If this amount is not paid within 60 days, then my credit or debit card will be charged for the entire balance owed for treatment of services to me.

I understand my insurance company will also provide notification of these charges with an explanation of benefits. In the event this amount exceeds \$250.00, the office will provide a courtesy call to my phone number.

I understand that in the event my credit or debit card has been charged for treatment or services, and then my insurance carrier subsequently makes a payment to the office for those charges, the office will issue a credit to my credit or debit card.

**PLEASE CIRCLE ONE OF THE FOLLOWING:**

VISA, MC, AMERICAN EXPRESS, OR DISCOVER

CARD/ACCOUNT NUMBER \_\_\_\_\_

EXPIRATION DATE \_\_\_\_\_ Security Code \_\_\_\_\_

NAME OF CARDHOLDER \_\_\_\_\_

I hereby authorize Michelle B Deutch, D.D.S. and its designated employees to charge my credit/debit card as designated above.

\_\_\_\_\_

Cardholder's Signature

\_\_\_\_\_

Date