Welcome to our office!

In order to serve you properly, we will need the following information (please print)

All information will be kept strictly confidential

Date:
Update:
Update:

Patient Information and History

A. Patient Name Last: First: MI.:

Address

(If P.O. Box, please give street address also)

City State Zip

Driver's Lic. # Social Sec. # - - D.O.B. / /

Sex: M ☐ F ☐ Marital Status

Home Phone # ( ) Work Phone # ( ) Ext. #

Cell Phone # ( ) Email Address @

Employer's Name or School Attending:

Closest Relative (not living with you)

Name Phone # Relationship

Emergency Contact (other than spouse)

Name Phone # Relationship

B. Responsible Party Information (Check if same as above) ☐ Social Sec.# - -

Name of Responsible Party D.O.B. Drivers Lic. #

Address Relationship to Patient

Email Address @

Home Phone ( ) Work Phone ( ) Cell Phone ( )

Employer's Name Employer's Phone ( )

Employer's Address

Spouse's Name Work or Cell # ( )

Spouse's Employer's Name Employer's Phone ( )

Employer's Address

C. Payment Information Payment and/or verification of insurance coverage is required at the time of treatment to cover your portion of fees not covered by insurance. We accept the following payment options. Please indicate your choice(s) of payment. We are happy to answer any question you may have.

☐ Cash ☐ Check ☐ Credit Card ☐ Finance Company

If you have dental insurance, please fill-in the following information:

Primary Insurance		**Secondary Insurance**	
Policy Holder's Name		Policy Holder's Name	
Name of Insurance		Name of Insurance	
Address		Address	
Phone ( )	Group #	Phone ( )	Group #
SS #	DOB	SS #	DOB

D. Referral

Who may we thank for referring you?

- ☐ Insurance Company
- ☐ Patient:
- ☐ Walk-in
- ☐ Yellow Page Ad
- ☐ Physician:
- ☐ Postcard or Mail Piece
- ☐ Sign / Billboard
- ☐ Newspaper (specify) :
- ☐ Other:

E. Payment & Treatment Consent

I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to thoroughly diagnose dental needs of _____. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I give my consent to use local anesthetics, relaxants, analgesia ("laughing gas"), antibiotics, or pain medication if deemed necessary for the completion of any dental treatment. I understand that the use of anesthetic agents embodies a certain risk. I also understand that responsibility for payment for dental services provided by this office for myself or my dependents is mine, due and payable at the time services are rendered unless other financial arrangements are made. In the event of default, I (we) promise to pay interest at the rate of 1.5% monthly on the indebtedness, together with all collection costs and reasonable attorney fees as may be required to effect the collection of this note. ***FEES NOT PAID BY THE INSURANCE COMPANY WITHIN 60 DAYS ARE PAYABLE FROM THE PATIENT OR THE RESPONSIBLE PARTY.***

Signature of Responsible Party X Relationship to Patient: Date:

F. Authorization

I hereby authorize my insurance benefits to be paid directly to the doctor's office and also authorize the doctor to release any information to process insurance claims.

Date Signature (insured) X

Date Signature (patient or guardian) X

G. Dental Services Acknowledgement

1. I understand that whenever a tooth is extracted, there is a possibility of infection, bone fracture, temporary paresthesia (numbness) of the lip, gum, tongue and/or facial skin. It is possible, although rare, that the paresthesia would be permanent.

2. I understand that root canal treatment is an attempt to retain a tooth that would otherwise require extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth undergoing root canal treatment may undergo acute infection. It may require re-treatment, surgery, or (rarely) extraction.

3. I understand that preparation of teeth for crowns, bridges, and fillings may, on occasion, traumatize the pulp (nerve). If the pulp (nerve) is in a weakened condition, this may necessitate a root canal treatment on that tooth in the future.

4. I realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on plan. Posterior teeth may be paid for at "silver" or amalgam filling rate. All restrictions are based on the premium paid for insurance and not our fees or recommended treatment.

5. Women taking birth control pills should be aware that antibiotics, such as penicillin or erythromycin, could possibly counteract the effects of the pill and you could become pregnant.

6. I realize that any of the work that the doctor proposes can be performed by a specialist. I will tell the doctor or his staff if I desire that a specialist perform the work.

7. I **do / do not** (circle one) grant permission to take photographs of my mouth or head and neck to used, without revealing my identity, for the furthering of medical and dental knowledge and education.

8. I understand that if I fail to give a 24 hour notice to cancel a scheduled appointment I can be charged a fee up to the amount of the scheduled appointment procedure. I also understand that any X-rays taken are property of the dentist, and that a fee may be charged for any duplication or transfer of said X-rays. I have not taken any mood or mind altering drugs prior to signing this form.

Date Signature X

DENTAL HISTORY

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

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

☐ Dentures ☐ Partial Dentures ☐ Braces ☐ Periodontal (gum) treatments

Please share the following dates:

Your last cleaning _____/_____

Your last oral cancer screening _____/_____

Your last complete X-Rays _____/_____

Name of Previous Dentist **City/State** **Phone**

_____

What is the most important thing to you about your future smile and dental health?

_____

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐ **Yes** ☐ **No**

Do you smoke or use chewing tobacco?

How much? For how long?

If I could change my smile, I would:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

_____

What is the most important thing to you about your dental visit today?

_____

MEDICAL HISTORY

Please check any of the following that apply to you: (* indicates conditions that may contribute to Gum Disease 'Oral Health')

- ☐ Acid Reflux
- ☐ AIDS
- ☐ Alcohol Addiction
- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Arthritis *
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease *
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy *
- ☐ Dementia/Alzheimers
- ☐ Diabetes *
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions *
- ☐ Heart Lesions (Congenital)
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse *
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Periodontal Disease
- ☐ Phen Fen (1 month +)
- ☐ Radiation (head/neck)
- ☐ Pregnant Currently
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Diseases
- ☐ Weight-loss Surgery
- ☐ Other

Do you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Darvon
- ☐ Nitrous Oxide
- ☐ Percodan
- ☐ Local Anesthetic
- ☐ Codeine
- ☐ Erythromycin
- ☐ Valium
- ☐ Penicillin
- ☐ Other

Are you under a physician's care? Specifically, for what?

_____

Are you taking any medications? Please list below

_____

Is there any other medical or dental information we should know about? _____

Print Name: _____

Signature (Patient or Guardian): _____ **Date:** _____

Dentist Signature: _____ **Date:** _____

Oral Screening Consent Form

Please initial each paragraph after reading. If you have any questions, Please ask your Doctor or Hygienist before Initialing.

_____1. Unlike several other cancers, the survival rate for oral cancer has remained unchanged for decades. The overall 5 year survival rate for oral cancer is 52%, but when it is discovered early, it increases to 80% - 90%. Unfortunately, only 35% of oral cancer cases are diagnosed in the early stages due to the limitations of the traditional oral cancer screening using white light only.

_____2. Pre-malignant changes in the tissue actually start below the surface. These changes may not be apparent to the naked eye until the disease progresses to the surface.

_____3. The known risk factors for oral cancer are: Patients age 40 and over, tobacco users, heavy use of alcohol, history of oral cancer, human papilloma virus (HPV16, HPV18). In the past three decades there has been a 60% increase in oral cancer in adults under the age of 40.

_____4. More than 25% of oral cancer victims have ***no*** lifestyle risk factors. **All patients over the age of 18 should be screened annually for oral cancer.**

_____5. We are concerned about oral cancer and screen for it on every patient. In addition to the traditional method of screening that we have used in the past, we are now adding a new tool for the screening of oral mucosal tissues.

_____6. To provide our patients with the optimal level of care, we have added the Velscope®, fluorescence visualization technology. The Velscope® uses a safe blue light that shines onto and through the oral tissue and has different fluorescence responses to help differentiate between normal and abnormal tissue. The Velscope® system is the only adjunctive device cleared by the FDA to help discover oral mucosal lesions that might not be apparent or visible to the naked eye. The screening is painless, non-invasive, with no rinses or stains required and will be completed during your visit today.

_____7. **This enhanced screening is recognized by the American Dental Association; however, this screening is not covered by your insurance. The fee for this enhanced screening is $35.00. We recommend this screening once per year.**

_____8. If you decline this enhanced Velscope® screening, we will still perform the traditional oral cancer surface screening, as we have in the past.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental screening I have authorized.

CONSENT: I have had the opportunity to have all my questions answered by my doctor and I certify that I understand English. My signature below signifies that I understand the screening that is proposed for me.

☐ **YES,** I authorize the clinician to perform the Velscope® screening along with the standard oral cancer Screening. I accept financial responsibility for this enhanced screening.

☐ **NO,** I would prefer not to have the Velscope® screening at this time.

Print Name:_____

Patient's (or Legal Guardian's) Signature:_____Date: _____

Witness' Signature:_____Date: _____

OFFICE POLICY

Welcome and thank you for choosing our office to meet your dental needs. We strive to give our patients the very best dental services available.

INSURANCE: Your insurance benefits are a contract between you and the insurance company. We are not a party to that contract. As a courtesy to you, we will bill your insurance for services. An estimate is given prior to any treatment, as we cannot guarantee what or if your insurance company will pay. You are responsible for all charges incurred regardless of your coverage. Your estimated co-payment is due at the time of service. Any remaining balance is your responsibility. If your account is turned over to collections, you are responsible for any charges incurred such as attorney fees, collection agency fees and/or court costs.

APPOINTMENTS: We do our best to see our patients on time. If you are unable to keep your appointment, please contact the office at least 24 hours in advance. We realize your time is important as well as ours. It is very costly when patients do not keep appointments. Our policy is to charge $150.00 for every hour that is scheduled. Thank you for your understanding.

X-RAYS: If you received any discounted promotion, you will be charged the full price should you decide to take copies of the x-rays with you.

If you have any questions, please contact us and we are happy to discuss any concerns you might have.

I have read and agree to the office policy.

_____

Signature/Date

Notice of Privacy Practices Acknowledgement

(HIPPA)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly*

☐ *Obtain payment from third-party payers.*

☐ *Conduct normal healthcare operations such as quality assessments and physician certifications.*

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time a the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name

Responsible Party (Print) Relationship to Patient

Signature of Responsible Party X Date

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: