

## Patient Information

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First M. I.

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ S.S.N. \_\_\_\_\_

Status: Married  Single  Child  Other  Gender: Male  Female

Home # (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Email address: \_\_\_\_\_

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

Work # (\_\_\_\_) \_\_\_\_\_ Ext # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Yelp  Google  Demand Force  Insurance Provider  Facebook   
Other  \_\_\_\_\_

## Emergency Contact Information

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to contact: \_\_\_\_\_

Do we have permission to release medical information during an emergency? Y  N

Primary Care Doctor \_\_\_\_\_ Phone: \_\_\_\_\_

## Dental History

Date of last dental visit: \_\_\_\_/\_\_\_\_ Reason for this visit: \_\_\_\_\_

Have you previously been diagnosed with periodontal disease? Y  N

Have you ever been told you require special cleanings (deep cleaning)? Y  N

Have you ever been seen by a dental specialist? Y  N  Name of doctor? \_\_\_\_\_

Are you currently having any pain or problems with your teeth?

Explain: \_\_\_\_\_

Do you ever experience jaw pain or popping? Y  N

Do you ever experience sensitivity around or at the gum line? Y  N

How do you feel about your smile?

Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Responsible Party Information

The following is for the person responsible for payment if different from the patient:

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

Relationship to patient  Spouse  Parent  Child  Other

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

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

Street Apartment #

City State Zip Code

Employer Name: \_\_\_\_\_ Occupation \_\_\_\_\_

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

Street City State Zip Code Phone

## Insurance Information

### Primary

Name of Policy Holder: \_\_\_\_\_ Is policy holder a patient?  Yes  No

Last First MI

Policy Holder's Birth Date: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_

Street City State Zip Code

Policy Holder's Employer Name: \_\_\_\_\_

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

Street City State Zip Code

Patient's relationship to Policy Holder:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Secondary

Name of Policy Holder: \_\_\_\_\_ Is policy holder a patient?  Yes  No

Last First MI

Policy Holder's Birth Date: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_

Street City State Zip Code

Policy Holder's Employer Name: \_\_\_\_\_

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

Street City State Zip Code

Patient's relationship to Policy Holder:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

## Consent for Services

As a condition of your treatment in this office, financial arrangements must be made in advance and credit information obtained when necessary. The practice depends upon reimbursement from the patients for costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I also certify that all the information I submitted in the Health Questionnaire Form I submitted is true and complete. In order to receive treatment, I contract that in the event of any difference or disagreement between the attending Dentist and me, I will give that Dentist an opportunity to resolve the problem. A service charge of 1 1/4% 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 the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or 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. I understand that this office is compliant with the HIPAA Act of 1996 and by signing this consent I authorize and disclose my health information for the operations of the practice. I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of guarantor of payment/responsible party \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Medical History

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of last medical exam: \_\_\_\_\_

What was that exam for? \_\_\_\_\_

Have you recently been hospitalized or had a major operation? Y  N

What: \_\_\_\_\_ When: \_\_\_\_\_

Have you had a serious head or neck injury? Y  N

What: \_\_\_\_\_ When: \_\_\_\_\_

Do you use tobacco? Y  N

Do you use controlled substances? Y  N

Do you/have you ever done any illegal drugs? Y  N

Are you on a special diet? Y  N

### Women

Are you pregnant or trying to get pregnant? Y  N

Due date: \_\_\_\_\_ Trimester: \_\_\_\_\_

Are you currently taking birth control? Y  N

Are you currently nursing? Y  N

Have you ever had to pre-medicate with an antibiotic before dental cleanings or treatment? Y  N

Have you ever taken Fosamax, Boniva or any other bisphosphonates? Y  N

## Allergies/Sensitivities

Are you allergic to any of the following? ("S" is for sensitivities if they are not true allergies)

Aspirin Y  N  S  Food Y  N  S  Sulfa Drugs Y  N  S

Anesthetic Y  N  S  Metals Y  N  S  Codeine Y  N  S

Epinephrine Y  N  S  Acrylics Y  N  S  Latex Y  N  S

Penicillin, Amoxicillin or Keflex Environmental Y  N  S

Y  N  S  Animals Y  N  S

Other antibiotic allergies Y  N  S  Please list: \_\_\_\_\_

Other allergies or sensitivities not listed above: \_\_\_\_\_

### LIST ALL MEDICATIONS, SUPPLEMENTS, AND VITAMINS (with doses):

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## Medical History

Today's date: \_\_\_\_\_

Acid Reflux or GERD	Y <input type="checkbox"/> No <input type="checkbox"/>	Dizziness	Y <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Y <input type="checkbox"/> No <input type="checkbox"/>
AIDS/HIV positive	Y <input type="checkbox"/> No <input type="checkbox"/>	Drug Addiction	Y <input type="checkbox"/> No <input type="checkbox"/>	Low Blood Pressure	Y <input type="checkbox"/> No <input type="checkbox"/>
Alzheimer's	Y <input type="checkbox"/> No <input type="checkbox"/>	Dry Mouth	Y <input type="checkbox"/> No <input type="checkbox"/>	Lung Disease	Y <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Y <input type="checkbox"/> No <input type="checkbox"/>	Eating Disorders	Y <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse	Y <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Y <input type="checkbox"/> No <input type="checkbox"/>	Emphysema	Y <input type="checkbox"/> No <input type="checkbox"/>	Osteoporosis	Y <input type="checkbox"/> No <input type="checkbox"/>
Artificial Heart Valve	Y <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Y <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Care	Y <input type="checkbox"/> No <input type="checkbox"/>
<b>When placed?</b> _____		Excessive Bleeding	Y <input type="checkbox"/> No <input type="checkbox"/>	Radiation Treatment	Y <input type="checkbox"/> No <input type="checkbox"/>
Artificial Joint	Y <input type="checkbox"/> No <input type="checkbox"/>	Frequent Cough	Y <input type="checkbox"/> No <input type="checkbox"/>	<b>When?</b> _____	
<b>What Joint?</b> _____		Frequent Diarrhea	Y <input type="checkbox"/> No <input type="checkbox"/>	Renal Dialysis	Y <input type="checkbox"/> No <input type="checkbox"/>
<b>When?</b> _____		Frequent Headaches	Y <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Y <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Y <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Y <input type="checkbox"/> No <input type="checkbox"/>	Rheumatism	Y <input type="checkbox"/> No <input type="checkbox"/>
Blood Disease	Y <input type="checkbox"/> No <input type="checkbox"/>	Growths	Y <input type="checkbox"/> No <input type="checkbox"/>	Scarlet Fever	Y <input type="checkbox"/> No <input type="checkbox"/>
Blood Transfusion	Y <input type="checkbox"/> No <input type="checkbox"/>	Heart Attack	Y <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Y <input type="checkbox"/> No <input type="checkbox"/>
Breath Problems	Y <input type="checkbox"/> No <input type="checkbox"/>	Heart Failure	Y <input type="checkbox"/> No <input type="checkbox"/>	Shingles	Y <input type="checkbox"/> No <input type="checkbox"/>
Bruise Easily	Y <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Y <input type="checkbox"/> No <input type="checkbox"/>	Sickle Cell Disease	Y <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Y <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease	Y <input type="checkbox"/> No <input type="checkbox"/>	Sinus Infections	Y <input type="checkbox"/> No <input type="checkbox"/>
<b>Type</b> _____		Hemophilia	Y <input type="checkbox"/> No <input type="checkbox"/>	Sinus Problems	Y <input type="checkbox"/> No <input type="checkbox"/>
<b>When:</b> _____		Hepatitis A	Y <input type="checkbox"/> No <input type="checkbox"/>	Sleep Apnea	Y <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy	Y <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis B	Y <input type="checkbox"/> No <input type="checkbox"/>	<b>Do you wear a C-PAP?</b>	Y <input type="checkbox"/> No <input type="checkbox"/>
<b>When:</b> _____		Hepatitis C	Y <input type="checkbox"/> No <input type="checkbox"/>	Stomach Issues	Y <input type="checkbox"/> No <input type="checkbox"/>
Chest Pains	Y <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Y <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Y <input type="checkbox"/> No <input type="checkbox"/>
Cold Sores/Fever Blisters	Y <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure	Y <input type="checkbox"/> No <input type="checkbox"/>	Swelling	Y <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Disease	Y <input type="checkbox"/> No <input type="checkbox"/>	High Cholesterol	Y <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Disease	Y <input type="checkbox"/> No <input type="checkbox"/>
COPD	Y <input type="checkbox"/> No <input type="checkbox"/>	Hyperglycemia	Y <input type="checkbox"/> No <input type="checkbox"/>	Tonsillitis	Y <input type="checkbox"/> No <input type="checkbox"/>
Crohn's Disease	Y <input type="checkbox"/> No <input type="checkbox"/>	Hypoglycemia	Y <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Y <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Y <input type="checkbox"/> No <input type="checkbox"/>	Irregular Heart Beat	Y <input type="checkbox"/> No <input type="checkbox"/>	Tumors	Y <input type="checkbox"/> No <input type="checkbox"/>
<b>Type I</b> _____ <b>or</b> <b>Type II</b> _____		Kidney Problems	Y <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Y <input type="checkbox"/> No <input type="checkbox"/>
		Leukemia	Y <input type="checkbox"/> No <input type="checkbox"/>		

**Any serious illness or health problems that require further clarification not on the previous page:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PAYMENT POLICY

We are pleased to offer our patients quality, state of the art dentistry. As a courtesy to the patient, we will bill the insurance for you. You are responsible for all charges incurred for your dental treatment. In order to maintain this type of service, we must insist upon the following payment guidelines:

## PPO INSURANCE

We are a provider for many PPO plans. Members of these plans are required to pay their co-payment at the time services are rendered. Any unpaid balance is the responsibility of the patient.

## PRIVATE INSURANCE

We work with all private insurance companies. We will estimate the patient's portion of fees according to the information given to us by your insurance company. This portion is due at the time services are rendered. Any unpaid balance, is the responsibility of the patient.

## NO INSURANCE

Uninsured patients will be responsible for payments in full, at the time services are rendered.

## FAILURE TO APPEAR

**There is a \$25.00 charge for all failed appointments without a 24-hour notice.**

## CHECK CHARGE

There is a \$25 charge for all returned checks. We accept local checks with picture I.D., most credit cards, and cash.

We hope our policy is not an inconvenience to our patients. We do appreciate you choosing our office for your dental needs. Thanks again for your patronage.

AGREED X \_\_\_\_\_

Patient's Signature

## Oral Cancer Facts:

- The fastest rate of Oral Cancer is in patients that do not smoke or drink and are below the age of 40.
- It is one of the easiest to treat when found early but has one of the lowest survival rates because it generally is found too late.
- The virus that causes cervical cancer, Human Papilloma Virus (HPV), is now believed to be a leading cause of oral cancer, making almost everyone at risk. It is believed that the virus can be transmitted simply through kissing.
- African Americans, poor access to healthcare, and those over 40 are at an increased risk.

### Please answer the following questions:

Have you ever had an oral cancer screening performed? YES NO

Do you regularly use sunblock to reduce sun exposure? YES NO

Do you eat a low amount of fruit and vegetables? YES NO

Have you ever had an area in your mouth that you were concerned about (sore, irritation)? YES NO

If YES, where? \_\_\_\_\_

Have you ever tested positive for HPV-Human Papillomavirus? YES NO

Have you ever smoked or used chew tobacco? YES NO

How many alcohol drinks per week? 0-5 5-10 15+

Have you ever had a Pap smear, mammogram or PSA performed? YES NO

For female patients:

Have you ever had a positive cervical Pap smear? YES NO



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

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

## Oral Abnormality Screening Consent Form

**We are very concerned about oral cancer and conduct screening examinations on every patient.**

The incidence of Oral Cancer continues to rise in the USA. The American Cancer Society indicates that in 2012, they expect an increase in this deadly disease that will surpass cervical, testicular, melanoma and many other more commonly known cancers. **Alarmingly, 25 % of the new oral cancer cases are people that do not have any of the traditional life style risk factors, such as age and tobacco and alcohol use.**

Traditionally, our dentists and hygienists have done oral cancer screening with the naked eye, but recently a new technology, the **VELscope** has received FDA approval. The **VELscope** (for Visually Enhanced Lesion scope) **will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.**

VELscope, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope handpiece and the hygienist or dentist may find tissue abnormalities at an earlier stage. Before the exam, the room is darkened and much like "desert storm night vision technology" the clinician can see changes in tissue that may not be visible to the eye. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

**The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. The normal fee for this procedure is \$65, however, the Doctor feels so strongly that every patient has this examination at least once a year our charge for this enhanced examination is only \$25. The VELscope exam may or may not be covered by dental insurances. As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure.**

**Please sign the area below to accept the financial responsibility for this procedure.**

Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients.

Thank you for your kind consideration.

**YES, I authorize the office to perform the VELscope examination.**

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

**No, I decline this procedure at this time.**

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

Signature \_\_\_\_\_ Date \_\_\_\_\_