The DENTAL Suite

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date_____ Home phone_____ Cell phone_____

Name_____ SS/HIC/Patient ID_____

Address_____ Email_____

City_____ State_____ Zip _____

Sex ___M ___F Age___ Birthdate_____ __married __widowed __single
___divorced __separated

Patient Employer/School_____ Occupation_____

Employer Address: _____

In case of emergency who should be notified?_____ Phone_____

Referral Source _____

DENTAL INSURANCE INFORMATION

Person responsible to account_____

Relation to patient_____ Birthdate_____ Soc. Sec. #_____

Address (if diff. from patient) _____Phone # _____

City _____ State_____ Zip_____

Insurance Company_____

Contract #_____Group # _____ Subscriber #_____

Health History

Name_____Date_____

What is the reason for your visit today?_____

Are you satisfied with your teeth's appearance? …… No Yes

Are you interested in Professional Whitening of your teeth? ……...……... No Yes

Are you interested in straightening of your teeth? ……..... No Yes

Are you interested in bad breath management techniques? ……..…… No Yes

Date of: Last Dental Visit_____Last Dental Cleaning_____Last Full Mouth X-Rays _____

What was done at your last dental visit _____

How often do you have dental examinations_____Previous Dentist's Name _____

Telephone_____Address_____

How often do you brush your teeth_____Do you use electric toothbrush …… No Yes

How often do you floss?_____What other dental aids do you use (toothpick, etc.)_____

Do you have any dental problems now? ……. No Yes

If yes, please describe _____

Do you feel nervous about having dental treatment? ……..…. No Yes If yes, what is your biggest concern?_____

Have you ever had an upsetting dental experience ……..... No Yes

If yes, please describe_____

Is there anything else about having dental treatment that you would like us to know? _____

What are your hobbies or special interests (sports etc.)_____

Are any of your teeth sensitive to:				**Have you ever had**		
● Hot or cold?	No	Yes		● Orthodontic treatment?	No	Yes
● Sweets?	No	Yes		● Oral Surgery?	No	Yes
● Biting or chewing?	No	Yes		● Periodontal (gum) treatment	No	Yes
● Have you noticed any mouth odors or bad tastes	No	Yes		● A bite plate or mouth guard	No	Yes
● Do you frequently get cold sores, blisters or any other oral lesions?	No	Yes		● A serious injury to the mouth or head?	No	Yes
● Do your gums bleed or hurt?	No	Yes		**Have you experienced:**		
● Have your parents experienced gum disease or tooth loss?	No	Yes		● Headaches, neckaches or shoulder aches	No	Yes
●Have you noticed any loose teeth or change in your bite	No	Yes		● Sore muscles (neck, shoulders, side of face)	No	Yes

● Does food tend to become caught in between your teeth	No	Yes		● Pain (side of face, joint, ear?)	No	Yes
Do you				● Clicking or popping of the jaw	No	Yes
● Clench or grind teeth while awake or asleep	No	Yes		● Difficulty in chewing on either side of the mouth?	No	Yes
● Bite your lips or cheeks regularly	No	Yes		● Difficulty in opening or closing the mouth?	No	Yes
● Mouth breathe while awake or asleep?	No	Yes		● Have tired jaws especially in the morning?	No	Yes

Date of last health care exam:_____What was this exam for?_____

Have you been hospitalized in the last 5 years? ..... No Yes

If yes, reason:_____

Are you currently receiving care?.....No Yes ► If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3._____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart (Surgery, Disease, Attack)	No	Yes		Heart Murmur	No	Yes
Latex Sensitivity	No	Yes		Anemia	No	Yes
Diabetes	No	Yes		Previous Biopsies	No	Yes
Epilepsy	No	Yes		Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form (specify)	No	Yes		Other Infections	No	Yes
Rheumatic Fever	No	Yes		Recurrent Illnesses	No	Yes
Asthma	No	Yes		Psychosis	No	Yes
HIV Positive or AIDS Related Complex	No	Yes		Liver Disease (including Jaundice)	No	Yes
Mitral valve prolapse	No	Yes		Unintentional Weight Loss/Gain	No	Yes
Abnormal Heart Condition	No	Yes		Glaucoma	No	Yes
Kidney Disease	No	Yes		Abnormal Bleeding from a cut	No	Yes
Joint Replacement	No	Yes		Sore/Enlarged Lymph Nodes	No	Yes
Venereal Disease	No	Yes		Emphysema or other Respiratory Illnesses	No	Yes

Women: ● Are you pregnant?_____ ● If no, are you planning a pregnancy in the near future? …..... No Yes

Are you a nursing mother?…… No Yes ● Are you taking birth control pills? ..... No Yes

Are you required to Pre-Medicate before dental treatment? ..... No Yes

Abnormal Blood Pressure? (Please circle)…… No Yes ► If yes, what is it usually: S …….. / D…… **Are you allergic or have you had a reaction to:**

a. **Local anesthetics ……..…. No Yes**
b. **Penicillin or other antibiotics ……..……..…..… No Yes**
c. **Aspirin ….……..…….....……. No Yes**
d. **Codeine, valium or other sedatives…….…….…….. No Yes**
e. **Other**_____

Do you smoke / chew tobacco? .,...…….... No Yes ► If so, how much do you smoke per day? _____

Please list any medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Are you taking Tagamet (Cimetidine)? …… No Yes ► If yes, how often? _____

Do you take Antacids? ……..…..… No Yes ► If yes, how often? _____

Are you taking any herbal supplements?…….. No Yes ► If yes, which ones?_____

Diet: Restricted Diet_____How many meals a day_____Food Allergies _____

Sugar in your diet: ☐ None ☐ Slight ☐ Moderate ☐ High

Do you have or have you had any disease, condition or problem not listed? ……. No Yes

If yes, please list _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

*Patient (Print Name)*_____*Patient Signature*_____*Date*_____

*Doctor (Print Name)*_____*Doctor Signature*_____*Date*_____

Payment Policy

We will provide you with a treatment plan estimating your cost and any insurance benefits for dental care that you may need. Our practice requests payment at the conclusion of each visit. For patients with insurance, the ***estimated*** co- payment is requested at this time. As a courtesy, we will be pleased to submit insurance claims on our patient's behalf. Please note that any remaining balance, after insurance payment or denial, is the patient's responsibility to pay.

For treatment provided, our practice accepts cash, personal checks, and major credit cards, such as American Express, Visa, MasterCard, and Discover.

If you need to make financial arrangements for your portion, please feel free to do so with our Office Manager, in advance of dental treatment. We will be happy to discuss payment plan options and customize a payment plan for you.

We respect your time and we make a sincere effort to see all our patients on time. We ask that you respect our time and call us 48 business hours in advance, if you must cancel or reschedule your appointment. We waive the fee the first time you cancel without 48 hours' notice, as we know emergencies do arise. **We charge a broken appointment fee of $100.00** the second time your appointment is cancelled with less than 48 hours' notice. The third time this occurs, we regret to charge you **$200.00 for broken appointment**. Please understand any changes in our schedule affects patients waiting to complete their dental care.

I have read and understand the practice's payment policy. Accounts not paid in a timely manner are subject to a late fee. I understand that if the terms of any payment agreement are broken, the account will immediately be turned over to a third party or collection agency.

_____ _____

Signature of patient and/or guarantor **Date**

Consent for Internet Communications

(optional - you May Refuse to Sign This Acknowledgement)

I grant my permission to The Dental Suite to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for The Dental Suite. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand The Dental Suite and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that The Dental Suite is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand The Dental Suite is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use The Dental Suite web site with my ID and password. I also agree to immediately notify The Dental Suite of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand The Dental Suite will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that The Dental Suite has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand The Dental Suite will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand The Dental Suite CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for The Dental Suite and grant The Dental Suite permission to securely upload my patient information to the web site.

_____ Date:_____e-mail _____ Relationship to Patient: _____

Signature of patient and/or guardian

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 attempted to obtain written acknowledgement of receipt of our Notice of Privacy 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)

_____

_____

_____

Velscope Oral Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral healthcare to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers age is the primary risk factor for oral cancer. Tobacco and alcohol are other major predisposing risk factors but **more then 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk: patient age 18 – 39
High risk: patients age 40 and older, tobacco users (any age, any type within 10 years)
Highest risk: patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); Previous history of oral cancer.

We have recently incorporated Velscope into our oral screening standard of care. We find that using Velscope along with standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. Velscope is similar to proven early detection procedures for other cancers such as mammography, PAP smear, and PSA. Velscope is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The Velscope exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this examination is **$25.00**.

Yes. I authorize the clinician to perform the Velscope exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print Name: _____

Signature: _____ Date: _____

No. I would prefer not to have the Velscope exam at this time.

Print Name: _____

Signature: _____ Date: _____