

Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date _____ Soc. Sec. # _____ Birthdate _____
Name _____ Home Phone _____
Last Name First Name Initial
Address _____ Cell Phone _____
City _____ State _____ Zip _____ E-mail _____
Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Additional Insurance

Insured Name _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

Dental History

Former Dentist _____ Date of Last X-Rays _____
 City, State _____ How Often Do You Floss? _____
 Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

Bad Breath <input type="checkbox"/>	Loose Teeth or Broken Fillings <input type="checkbox"/>	Sensitivity to Sweets <input type="checkbox"/>
Bleeding Gums <input type="checkbox"/>	Orthodontic Treatment <input type="checkbox"/>	Sensitivity When Biting <input type="checkbox"/>
Blisters on Lips or Mouth <input type="checkbox"/>	Pain Around Ear <input type="checkbox"/>	Frequent Headaches <input type="checkbox"/>
Finger Nail Biting <input type="checkbox"/>	Periodontal Treatment <input type="checkbox"/>	Jaw, Head or Neck Injuries <input type="checkbox"/>
Grinding Teeth <input type="checkbox"/>	Sensitivity to Cold <input type="checkbox"/>	Jaw Difficulty: Clicking and/or Pain <input type="checkbox"/>
Lip or Cheek Biting <input type="checkbox"/>	Sensitivity to Heat <input type="checkbox"/>	Tooth Pain <input type="checkbox"/>

Medical History

Physician's Name _____ Date of Last Visit _____

<p>1. Are you currently under medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever had any serious illnesses or operations? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please describe: _____</p> <p>4. Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use alcohol, cocaine or other drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please check all that apply:</p> <table border="0" style="width: 100%;"> <tr> <td>AIDS <input type="checkbox"/></td> <td>Emphysema <input type="checkbox"/></td> </tr> <tr> <td>Anemia <input type="checkbox"/></td> <td>Epilepsy <input type="checkbox"/></td> </tr> <tr> <td>Arthritis, Rheumatism <input type="checkbox"/></td> <td>Fainting or Dizziness <input type="checkbox"/></td> </tr> <tr> <td>Artificial Heart Valves <input type="checkbox"/></td> <td>Glaucoma <input type="checkbox"/></td> </tr> <tr> <td>Artificial Joints <input type="checkbox"/></td> <td>Headaches <input type="checkbox"/></td> </tr> <tr> <td>Asthma <input type="checkbox"/></td> <td>Heart Murmur <input type="checkbox"/></td> </tr> <tr> <td>Back Problems <input type="checkbox"/></td> <td>Heart Problems <input type="checkbox"/></td> </tr> <tr> <td>Bleeding abnormally, with extractions or surgery <input type="checkbox"/></td> <td>Hepatitis-Type _____ <input type="checkbox"/></td> </tr> <tr> <td>Blood Disease <input type="checkbox"/></td> <td>Herpes <input type="checkbox"/></td> </tr> <tr> <td>Cancer <input type="checkbox"/></td> <td>High Blood Pressure <input type="checkbox"/></td> </tr> <tr> <td>Chemical Dependency <input type="checkbox"/></td> <td>HIV Positive <input type="checkbox"/></td> </tr> <tr> <td>Chemotherapy <input type="checkbox"/></td> <td>Jaundice <input type="checkbox"/></td> </tr> <tr> <td>Chronic Fatigue Syndrome <input type="checkbox"/></td> <td>Jaw Pain <input type="checkbox"/></td> </tr> <tr> <td>Circulatory Problems <input type="checkbox"/></td> <td>Kidney Disease <input type="checkbox"/></td> </tr> <tr> <td>Congenital Heart Lesions <input type="checkbox"/></td> <td>Latex Sensitivity <input type="checkbox"/></td> </tr> <tr> <td>Cortisone Treatments <input type="checkbox"/></td> <td>Liver Disease <input type="checkbox"/></td> </tr> <tr> <td>Cough - persistent or bloody <input type="checkbox"/></td> <td>Low Blood Pressure <input type="checkbox"/></td> </tr> <tr> <td>Diabetes <input type="checkbox"/></td> <td>Mitral Valve Prolapse <input type="checkbox"/></td> </tr> <tr> <td></td> <td>Nervous Problems <input type="checkbox"/></td> </tr> </table>	AIDS <input type="checkbox"/>	Emphysema <input type="checkbox"/>	Anemia <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Arthritis, Rheumatism <input type="checkbox"/>	Fainting or Dizziness <input type="checkbox"/>	Artificial Heart Valves <input type="checkbox"/>	Glaucoma <input type="checkbox"/>	Artificial Joints <input type="checkbox"/>	Headaches <input type="checkbox"/>	Asthma <input type="checkbox"/>	Heart Murmur <input type="checkbox"/>	Back Problems <input type="checkbox"/>	Heart Problems <input type="checkbox"/>	Bleeding abnormally, with extractions or surgery <input type="checkbox"/>	Hepatitis-Type _____ <input type="checkbox"/>	Blood Disease <input type="checkbox"/>	Herpes <input type="checkbox"/>	Cancer <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Chemical Dependency <input type="checkbox"/>	HIV Positive <input type="checkbox"/>	Chemotherapy <input type="checkbox"/>	Jaundice <input type="checkbox"/>	Chronic Fatigue Syndrome <input type="checkbox"/>	Jaw Pain <input type="checkbox"/>	Circulatory Problems <input type="checkbox"/>	Kidney Disease <input type="checkbox"/>	Congenital Heart Lesions <input type="checkbox"/>	Latex Sensitivity <input type="checkbox"/>	Cortisone Treatments <input type="checkbox"/>	Liver Disease <input type="checkbox"/>	Cough - persistent or bloody <input type="checkbox"/>	Low Blood Pressure <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Mitral Valve Prolapse <input type="checkbox"/>		Nervous Problems <input type="checkbox"/>	<p>7. 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Assignment and Release

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 have received, read and understand 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 at the address above to obtain a current copy of the *Notice of Private 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 health care 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 _____

Relationship to Patient: _____

Signature: _____

Date _____

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

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.**

Oral Cancer Risk profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with any of the following:
 - Tobacco use
 - Chronic alcohol consumption
 - Oral HPV infection

Highest risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer
- **25% of oral cancers occur in people who don't smoke and have no other risk factors.**

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is \$ 65.

Yes, I authorize the clinician to perform the ViziLite Plus 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 ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____

