WELCOME

one — ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____ LAST ____ FIRST ____ MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: ____ SS#: ____

Mailing Address: ____

____ CITY ____ STATE ____ ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

____ CITY ____ STATE ____ ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two — INSURANCE INFO

Primary Dental Insurance

Co. Name: ____

Address: ____

____ CITY ____ STATE ____ ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ___/___/___

Insured's Employer: ____

Secondary Dental Insurance

Co. Name: ____

Address: ____

____ CITY ____ STATE ____ ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ___/___/___

Insured's Employer: ____

three — ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

____ CITY ____ STATE ____ ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____ ___/___

❑ Credit Card - Enter card # above (if accepted)

____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four — IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

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DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? ____________

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth
❑ Other: ____________

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ____________ (____) ____________
Name Phone#

Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___

Times a day you brush? ________ Times a week you floss? ________

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6 six

MEDICAL HISTORY

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **Other(s), please list:** ____________

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: ____________

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin
❑ Dental Anesthetics ❑ Foods: ____________ ❑ Others: ____________

Do you use tobacco? ❑ No ❑ Yes/How used? ________ How much? ______ How long? ______

Please rate your general health from 1-10: ________ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? ______

Are you Pregnant? ❑ No ❑ Yes/How long? ______ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

______ **I acknowledge that I have received a copy of the Summary of Privacy Notice.**
Initials

Signature ____________ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

______ ___/___/___
Initials Date
____
Comments

______ ___/___/___
Initials Date
____
Comments

______ ___/___/___
Initials Date
____
Comments

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I ____ have received a copy of this office's Notice of Privacy Practices.

Print Name: ____

Sign: ____

Date: ___________________________

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, __________________________ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

____

{Please Print Name} Relationship

____

{Please Print Name} Relationship

____

{Please Print Name} Relationship

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) ____

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Office Policy

So that the office can better serve you, we find it necessary to have all patients read and understand our office policy. If you have any questions please feel free to ask the staff.

BROKEN APPOINTMENTS

Please understand that appointment time in any dental office is limited and valuable. Therefore, we request kindly that all patients honor their reserved appointment time. Failure to do so deprives other patients from receiving needed dental care in a timely fashion.

So that I the dentist and my staff will not be penalized by those who fail to keep their appointments, $50.00 per hour broken fee Monday- Thursday and a $75.00 charge per hour broken fee Friday/Saturday. This fee will not be charged if we receive 24 hour notice for Monday-Thursday and a 48 hour notice Friday/Saturday prior to your scheduled appointment time. The patient is responsible for the charge and it is to be paid prior to the scheduling of any new appointment.

FEES AND FINANCIAL ARRANGEMENTS

Any patient with insurance must bring in an insurance card. It is the patient's responsibility to advise the staff of any insurance changes along with address and phone numbers of the insurance company.

TREATMENT RECOMMENDATIONS

Dr. Lee and her staff strive to provide the most accurate and most complete treatment plan possible. In the event there is a discrepancy between the fees presented in the treatment plan and the final amount, keep in mind we estimate the insurance coverage and the insurance company may pay less or more than was estimated. Also, Dr. Lee may have to alter her original treatment in order to provide the best dental care for you.

ACCOUNTS WITH DENTAL INSURANCE

Please remember that if we accept and file your insurance, it is a courtesy to you. However the relationship is between you and your insurance company. The patient is always responsible for his or her portion at the time service is performed. After 30 days the total amount becomes the responsibility of the patient or the guarantor. (parent or guardian) Unless arrangements are made with the office, the account will then be susceptible for collections. Please note that our office will not be responsible for filing secondary claims; this is the responsibility of the patient.

WE ACCEPT CASH, CHECK, DEBIT, VISA, MASTERCARD, AND DISCOVER

Signature____________________________ Date________________________

ViziLitePRO

Oral Lesion Screening System

Adjunctive Oral Abnormalities Screening Form

Complete each time the exam is offered and place in the patient's file

Our practice continually strives to provide important enhancements in oral healthcare for our patients. We are concerned about your oral abnormalities and their relationship with serious diseases such as oral cancer. For this reason, we offer screenings to every patient for early detection.

Oral cancer is one of the deadliest diseases we encounter and research shows that the late detection of oral cancer is the primary reason that mortality rates are high. As is the case with most other cancers, age is a primary risk factor for oral cancer. Tobacco use and chronic alcohol consumption are also major risk factors.

We find that using ViziLite PRO- along with a visual examination- improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of abnormalities can minimize or eliminate the harmful and potentially disfiguring effects of serious oral diseases such as cancer, and possibly save your life. A painless exam gives us a better chance of finding any oral abnormalities you may have at an early stage. In our practice, the exam will be offered to you annually.

Dental insurance may or may not cover the exam. However, our office i

s happy to verify your coverage for you. We are asking patients pay the fee upfront, and we will file it to your insurance. The fee for this exam is **$15.00** .

☐ Yes. I authorize my dental professional to perform the ViziLite PRO screening along with the standard oral examination. I accept financial responsibility for this exam.

☐ No. I would prefer not to have abnormality screening at this time.

Print name:____

Signature______________________________ Date:________________

Oral cancer risks include:

- Tobacco use
- Chronic alcohol consumption
- Oral HPV 16/18 infection

1-800-4DENMAT
(1-800-433-6628)
www.denmat.com

DenMat®