NOVA Dental Practice

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PATIENT INFORMATION

Name: _____ _____ _____ _____ Gender: ☐Male / ☐Female
Last First MI (Preferred Name)

Date of Birth: _____ SSN#: _____ Family Status: ☐ Married / ☐ Single / ☐ Child

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip

E-mail: _____

Telephone: (Home) _____ (Work) _____ (Mobile) _____

HEALTH INFORMATION

Reason for today's visit: _____ Last Dental Visit Date: _____

Have you ever had any of the following? ONLY CHECK THOSE THAT APPLY:

☐Aids
☐Allergy – Amoxicillin
☐Allergy – Codeine
☐Allergy – Latex
☐Allergy – Penicillin
☐Allergy – Seasonal
☐Allergies
_____
☐Alzheimer's
☐Anemia
☐Arthritis
☐Artificial Joints
☐Blood Disease
☐Cancer
_____
☐Depression
☐Diabetes
☐Dizziness
☐Epilepsy
☐Excessive Bleeding
☐Fainting
☐Glaucoma
☐Heart Surgery
☐Hay Fever
☐Head Injuries
☐Heart Disease
☐Heart Murmur
☐Hepatitis
☐High Blood Pressure
☐Human Papillomavirus (HPV)
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Mental Disorders
☐Nervous Disorders
☐Pacemaker
☐Pregnant Due Date
_____
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatic Fever
☐Rheumatism
☐Sinus Problems
☐Stomach Problems
☐Stroke
☐Tuberculosis
☐Tumors
☐Ulcers
☐Venereal Disease
☐Other:
_____

Are you taking any medications? ☐ Yes / ☐ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes / ☐ No

If yes, please explain: _____

Do you have any health problems that need further clarification? ☐ Yes / ☐ No

If yes, please explain: _____

Are you under the care of a physician? ☐ Yes / ☐ No

If yes, please explain: _____

Name of physician: _____ Phone: _____

Have you ever had any complications following dental treatment? ☐ Yes / ☐ No

If yes, please explain: _____

Do you experience teeth sensitivity? ☐ Yes / ☐ No

If yes, please explain: _____

Have you been advised to pre-medicate with antibiotics? ☐ Yes / ☐ No
Do you use dental floss daily? ☐ Yes / ☐ No
Do your gums bleed? ☐ Yes / ☐ No
Do you clench or grind your teeth? ☐ Yes / ☐ No
Does your jaw hurt or click? ☐ Yes / ☐ No
Do you smoke cigarettes or chew tobacco? ☐ Yes / ☐ No
Interested in changing the appearance of your teeth – shape or whiteness? ☐ Yes / ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I understand that it is my responsibility to inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, or guardian if patient under 18 Date

INSURANCE POLICY HOLDER INFORMATION

The following person is responsible for payment: **(IF SAME AS PATIENT, LEAVE BLANK)**

Name: _____ _____ _____ _____ Gender: ☐Male / ☐Female
Last First MI (Preferred Name)

Birth Date: _____ SSN# / LIC #: _____ Family Status: ☐ Married / ☐ Single

Telephone: (Home) _____ (Work) _____ (Mobile) _____

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip

E-mail: _____

POLICY HOLDER EMPLOYMENT INFORMATION

Employer Name: _____ Occupation:_____

Address: _____ _____
Street Apartment #

_____ _____ _____
City State Zip

Telephone: _____

CONSENT FOR SERVICES

We are pleased that you have chosen us for your dental care! We are committed to providing you with the highest quality of services available. Everyone benefits when there is a clear understanding of financial policies prior to treatment and we make every effort to keep down the cost of your dental care. We accept most major insurances, and for your added convenience accept Visa, MasterCard, Discover, American Express, and Care Credit. As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

We must emphasize that as your Dental Care Provider, our relationship is with you and not your insurance carrier. 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 insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1½% 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 each dental care procedure can only be extended for a period of six months from the date of the patient examination. I also understand that any amount quoted to me is simply an estimate, and may increase or decrease depending on what the insurance company covers.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the value of said services to said Doctor, or his assignee, at the time said services are rendered, or within the time of extension agreed upon. I further agree that the value of said services shall be as billed unless objected to, by me, in writing, within the time for payment. 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 instated hereunder. I grant my permission to you or your assignee, to telephone me at home or at my 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, or guardian if patient under 18 Date

REFERRAL INFORMATION

How did you find our office? (Select all that apply)

A. Google Search
B. Yelp Reviews
C. Shopping Center / Sign
D. Postcard / mailer sent to home
E. Patient from previous office: _____
F. Referred by person/practice: _____
G. Through insurance network: _____
H. Other: _____

CANCELLATION NOTICE MUST BE PROVIDED AT LEAST 24 HOURS IN ADVANCE

We reserve the right to charge for appointments broken without at least 24 hours advance notice.

Thank you! We appreciate your consideration.

FINANCIAL POLICIES

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, AND CREDIT.

INSURANCE
Some services require a pre-determination (written authorization by your insurance) prior to treatment- in most cases these are not recommended because they can delay your treatment for months and situations in the mouth can worsen. If you opt not to wait for this process, we require you to pay in full. We will bill your insurance company as a courtesy to you, and refund any over-collection of payment from you at our office. In order to properly file your claims, we must have the most up-to-date information regarding your insurance coverage. For this reason, you may be asked to present your insurance card(s) at each visit. It is your responsibility to provide all insurance cards (medical and dental), identification, authorization, and referral information, and to notify our office immediately of any information changes when they occur. *Failure to provide all required information may necessitate in patient payment for all charges.* Any amount we tell you is considered to be an estimate based on information we have received from your insurance; ***should insurance not cover any treatment, your signature shows your understanding and acceptance for the responsibility of all costs.***

CO-PAYMENT FOR APPOINTMENTS
We require *deductible and co-payments to be paid in full at the time of service*. A down payment will be collected for treatment appointments (half of the estimated co-payment) at the time of scheduling. The remaining half will be collected on the date of service- should the appointment be missed or cancelled without sufficient notice, this will be applied towards the missed appointment fee. Please note that it is insurance ESTIMATES that are provided which is not a guarantee of payment. You as the policy holder are responsible for knowing your insurance benefits, maximums, and usage.

MISSED APPOINTMENTS
Unless cancelled at least 48 hours in advance, *our policy is to charge $50.00 per half-hour no show fee*. Two consecutive missed appointments without 48 hours cancellation notice may result in a cessation of treatment by the dentist. Consecutive late cancellations and missed appointments will result in requiring a deposit in full ($50/half-hour or co-payment) for the visit to secure the time slot for the patient and doctor- this deposit will be deducted from the co-payment for that visit at the time of the scheduled treatment, or will be kept for a late cancellation or missed appointment.

RETURNED CHECKS
In the event that a check is returned for insufficient funds, we will call to notify you and give you 10 days to pay the amount in full and any bank charge fee with cash. If we do not receive the cash payment in full within 10 days, a $50 returned check fee will be added to your account.

COLLECTION FEES
In the event that your account is turned over to a collection agency, you will be responsible for all unpaid balances including any collections costs and any reasonable attorney fees. Any discounts previously given will be cancelled and added to the total due, and late fees will incur.

RECORD RELEASE FEES
Patients are entitled under federal law to have access to their protected health information. We are able to provide all patients with one copy of their records but will charge a $50 fee for any additional copies requested.

I have read the above Financial Policies and I understand and agree to them.

_____ _____
Signature of patient, or guardian if patient under 18 Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

_____	_____	_____	_____
Full name	Relationship to Patient	Full name	Relationship to Patient
_____	_____	_____	_____
Full name	Relationship to Patient	Full name	Relationship to Patient

By signing below, I acknowledge that I agree to this office's Notice of Privacy Practices, and allow the office to submit my insurance claims on my behalf.

_____
Printed name of patient

_____
Signature of patient, or guardian if patient under 18

_____
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 was presented with privacy practices but refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (Please specify)_____

Staff Member Printed Name: _____ Staff Member Signature _____ Date _____

Smile Evaluation

A Simple Evaluation to Help You Obtain the Smile You've Always Wanted

Hold a mirror 12"–14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, and then answer the following questions:

1. Do you like the appearance of your teeth and your smile? □**Yes** □ **No**
If not, explain _____
_____

2. Are your teeth all in alignment (straight)? □ **Yes** □ **No**
If not, explain _____
_____

3. Do you have spaces that you don't like? □ **Yes** □ **No**
If yes, explain _____
_____

4. Do you like the color of your teeth? □ **Yes** □ **No**
If not, explain _____
_____

5. Do you like the shape of your teeth? □ **Yes** □ **No**
If not, explain _____
_____

6. Are your teeth…
Chipped □ **Yes** □ **No** Protruding □ **Yes** □ **No** Hidden □ **Yes** □ **No**
If yes, explain _____
_____

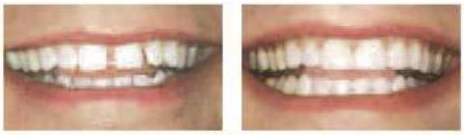
7. Are your teeth wearing on the biting surfaces? □ **Yes** □ **No**
If yes, explain _____
_____

8. Are there old fillings or dental work you don't like looking at? □ **Yes** □ **No**
If yes, explain _____
_____

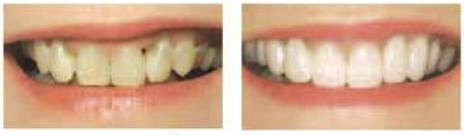
9. What would you like to change the most in the appearance of your teeth?
_____
_____

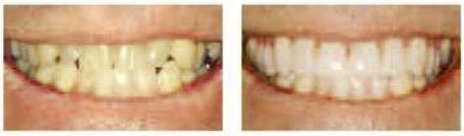
10. 10 How would you like your teeth to look?
_____
_____


STAINED AND CHIPPED


SPACES


CALCIFICATION STAINS


FANGED TEETH


STAINED AND CROOKED TEETH


PORCELAIN CROWNS


BEAUTIFUL SMILE

If you are not happy with the appearance of your teeth, ask your dentist how they can improve your smile.

Oral Screening Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care 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 use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papillomavirus (HPV) plays a role in more than 20% of oral cancer causes.*

Oral cancer risks by patient profile are as follows:

Increased risk: patients ages 18-39; sexually active patients (HPV)

High risk: patients age 40 and older; tobacco users (ages 18-39, 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 (Visually Enhanced Lesion scope) into our oral screening **standard of care**. We find that using VELscope along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope, along with the doctor's visual exam, is similar to other proven early cancer detection procedures, such as mammogram, Pap smear, and PSA test. VELscope is a simple, safe (no radiation) and painless examination that gives the best chance to find any 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-2007/08 procedure code D0431. Your estimated portion for this enhanced examination is **$45.**

❒ Yes. I would prefer to have the VELscope exam at this time.

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

Print Name _____

Signature _____ Date _____

*U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, NIDCR, NIH, 2000