Pelham Oaks Cosmetic Family Dentistry

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Welcome to our Family Practice. We consider this a privilege and honor to allow us to care for your dental needs. Our staff is committed to serve you in the most professional manner. To insure that your health is safeguarded to the utmost, we ask that you complete the following questionnaire as accurately as possible. Rest assured this information is held in strict medical confidence.

PATIENT INFORMATION

Date ___/___/___

Name _____ (Last) (First) (Middle)

Street Address _____

City _____ ST _____ Zip _____

S.S. #	- -
Gender	Male Female
Birth Date	

E-mail Address _____ Home Phone _____ **Cell Phone or Pager** _____

Employer _____ Work Phone _____

Driver's License# _____ If patient is a minor, give parent's or guardian's name _____

Emergency contact person (other than spouse): _____ Relationship _____

Address: _____ Phone number _____

Whom may we thank for referring you to our office? _____

SPOUSE INFORMATION

Spouse's Name _____ (Last) (First) (Middle)

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ D.O.B. _____

Social Security # _____ Employer _____

RESPONSIBLE PARTY INFORMATION

Name _____ (Last) (First) (Middle) _____ (Marital Status)

Social Security # _____ D.O.B. _____ Relationship to Patient _____

Employer _____ Work Phone _____ Occupation _____ No. Years Employed ____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Insured Name _____

Date of Birth _____

Insured Social Security # _____

Insured Employer _____

Relationship to patient _____

Secondary Dental Insurance

Insured Name _____

Date of Birth _____

Insured Social Security # _____

Insured Employer _____

Relationship to patient _____

(PLEASE COMPLETE REVERSE SIDE)

FORM 096683 R/02/12 ITEM 8101

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

DENTAL HISTORY

Do you have a specific dental problem? Describe _____

Do you have dental examinations on a routine basis? Last visit? _____

Do you ever have clicking or discomfort in the jaw joints (TMJ)? Discuss _____

Name of previous dentist (optional) _____

MEDICAL HISTORY

Are you under a physician's care now? Doctor's name?	Yes	No	_____
Have you ever been hospitalized or had a major operation?	Yes	No	_____
Have you ever had a serious head or neck injury?	Yes	No	_____
Are you taking any medications, pills, or drugs?	Yes	No	List Medications: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Are you on a special diet?	Yes	No	Do you use tobacco? Yes No
Do you use controlled substances?	Yes	No	Can we help you quit smoking? Yes No

WOMEN Are you: ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? Do you have any allergies? Please list: _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Please Check if you have had any of the following:

AIDS / HIV Positive	Chest Pain	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores / Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack / Failure	Low Blood Pressure	Spina Bifida
Arthritis / Gout	Diabetes	Heart Murmur*	Lung Disease	Stomach / Intestinal Disease
Artificial Heart Valve*	Drug Addiction	Heart Pacemaker*	Mitral Valve Prolapse*	Stroke
Artificial Joint*	Easily Winded	Heart Trouble / Disease	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells / Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives or Rash	Rheumatic Fever*	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No N/A

Comments: _____

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

_____

Signature of Patient, Parent or Guardian Date

INSURANCE ASSIGNMENT RELEASE

Please read and sign this statement before we agree to accept assignment directly from your insurance company. This avoids any misunderstandings and facilitates processing of your insurance claim. If you have any questions, please ask us. Thank you.

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 30 days, I will be responsible for the full amount owed to Pelham Oaks Dental. I understand that the balance will be charged to my credit card that I have on file with this office.

I understand that after the insurance company pays there could still be a balance remaining for which I am responsible. I understand and agree that I am responsible for this amount in full. I understand and agree that this balance will be charged to my credit card that I have on file with this office.

If I choose not to have a credit card on file with Pelham Oaks Dental, I understand that my estimated portion is due at the time of service.

My credit card on file is: Visa, Mastercard, American Express, Discover

#_____Expiration Date:_____

Name as it appears on the credit card_____

My signature on this form also constitutes signature on file. This enables this dental office to submit insurance forms on my behalf without my signature.

_____

Signature of Responsible Party Date

I do not choose to leave a credit card on file. I understand that I am responsible for any balance on my account.

_____

Signature of Responsible Party Date

Pelham Oaks Dental, 1412 Pelham Road, Greenville, South Carolina, 29615

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 acknowledge that I have received 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 Privacy 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:_____Intitials:_____Reason:_____

_____

Oral Screening Consent Form

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

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.** Oral cancer risk by patient profile is as follows:

Increased risk: *patients ages 18-39*
-sexually active patients (HPV 16/18)
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 ViziLite® Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus 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 ViziLite Plus 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: however. this exam might not be covered by your insurance. The fee for this enhanced examination is $60.00

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: _____