Patient Information

Today's date: ________

Name: ______________________________ **Preferred Name:** __________
Last First M.I.

Date of birth: ____/____/____ **S.S.N.** _____-_____-_____

Status: Married ☐ Single ☐ Child ☐ Other ☐ **Gender:** Male ☐ Female ☐

Home # (_____) _______-_________ **Cell # (_____)** _______-_________

Address: ______________________________ **Apt. #** ________

City/State/Zip: ____________________ **Email address:** ____________

Employer: ____________________ **Occupation:** ____________

Work # (_____) _______-_________ **Ext #** ________

Whom may we thank for referring you? ______________________________

Yelp ☐ **Google** ☐ **Demand Force** ☐ **Insurance Provider** ☐ **Facebook** ☐
Other ☐ ______________________________

Emergency Contact Information

Emergency Contact: ____________________ **Phone:** ____________

Relationship to contact: ______________________________

Do we have permission to release medical information during an emergency? Y ☐ **N** ☐

Primary Care Doctor ____________________ **Phone:** ____________

Dental History

Date of last dental visit: ____/____ **Reason for this visit:** ______________________

Have you previously been diagnosed with periodontal disease? Y☐ N☐

Have you ever been told you require special cleanings (deep cleaning)? Y☐ N☐

Have you ever been seen by a dental specialist? Y☐ N☐ Name of doctor? ____________

Are you currently having any pain or problems with your teeth?

Explain ______________________________

Do you ever experience jaw pain or popping? Y☐ N☐

Do you ever experience sensitivity around or at the gum line? Y☐ N☐

How do you feel about your smile?

Explain: ______________________________

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PAYMENT POLICY

We are pleased to offer our patient quality, state of the art dentistry. As a courtesy to the patient, we will bill the insurance for you. You are responsible for all charges incurred for your dental treatment. In order to maintain this type of service, we must insist upon the following payment guidelines:

PPO INSURANCE

We are a provider for many PPO plans. Members of these plans are required to pay their co-payment at the time services are rendered. Any unpaid balance is the responsibility of the patient.

PRIVATE INSURANCE

We work with all private insurance companies. We will estimate the patient's portion of fees according to the information given to us by your insurance company. This portion is due at the time services are rendered. Any unpaid balance, is the responsibility of the patient.

NO INSURANCE

Uninsured patients will be responsible for payments in full, at the time services are rendered.

FAILURE TO APPEAR

There is a $25.00 charge for all failed hygiene appointments without a 24-hour notice.
There is a $50.00 charge for all failed scheduled treatment appointments without a 24-hour notice.

CHECK CHARGE

There is a $25 charge for all returned checks. We accept local checks with picture I.D., most credit cards, and cash.

We hope our policy is not an inconvenience to our patients. We do appreciate you choosing our office for your dental needs. Thanks again for your patronage.

AGREED X______________________________________

Patient's Signature

Medical History

Today's date: ______________

Name: ______________________ **Date of last medical exam:** ______________

What was that exam for? ______________

Have you recently been hospitalized or had a major operation? Y ☐ N ☐

What: ______________________ **When:** ______________________

Have you had a serious head or neck injury? Y ☐ N ☐

What: ______________________ **When:** ______________________

Do you use tobacco? Y ☐ N ☐

Do you use controlled substances? Y ☐ N ☐

Do you/have you ever done any illegal drugs? Y ☐ N ☐

Are you on a special diet? Y ☐ N ☐

Women

Are you pregnant or trying to get pregnant? Y ☐ N ☐

Due date: ______________ **Trimester:** ______________

Are you currently taking birth control? Y ☐ N ☐

Are you currently nursing? Y ☐ N ☐

Have you ever had to pre-medicate with an antibiotic before dental cleanings or treatment? Y ☐ N ☐

Have you ever taken Fosamax, Boniva or any other bisphosphonates? Y ☐ N ☐

Allergies/Sensitivities

Are you allergic to any of the following? ("S" is for sensitivities if they are not true allergies)

Aspirin Y ☐ N ☐ S ☐

Anesthetic Y ☐ N ☐ S ☐

Epinephrine Y ☐ N ☐ S ☐

Penicillin, Amoxicillin or Keflex Y ☐ N ☐ S ☐

Other antibiotic allergies Y ☐ N ☐ S ☐

Metals Y ☐ N ☐ S ☐

Acrylics Y ☐ N ☐ S ☐

Sulfa Drugs Y ☐ N ☐ S ☐

Codeine Y ☐ N ☐ S ☐

Latex Y ☐ N ☐ S ☐

Please list: ______________________________________

Other allergies or sensitivities not listed above: ______________________________________

LIST ALL MEDICATIONS, SUPPLEMENTS AND VITAMINS (with doses):

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Consent for Services

As a condition of your treatment in this office, financial arrangements must be made in advance and credit information obtained when necessary. The practice depends upon reimbursement from the patients for costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed. 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 the patient's 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. I also certify that all the information I submitted in the Health Questionnaire Form I submitted is true and complete. In order to receive treatment, I contract that in the event of any difference or disagreement between the attending Dentist and me, I will give that Dentist an opportunity to resolve the problem. 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 this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me in writing, within the time for payment thereof. I further agree that a waiver of any breech of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree HIPPA Act of 1996 and by signing this consent I authorize and disclose my health information for the operations of the practice. I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________ Date: ____________ Relationship to Patient: ______________

Signature of patient, parent or guardian

______________________ Date: ____________ Relationship to Patient: ______________

Signature of guarantor of payment/responsible party

Medical History

Today's date: ________________

Condition	Y	N
Acid Reflux or GERD	Y ☐	N ☐
AIDS/HIV Positive	Y ☐	N ☐
Alzheimer's	Y ☐	N ☐
Anemia	Y ☐	N ☐
Arthritis	Y ☐	N ☐
Artificial Heart Valve	Y ☐	N ☐
When placed: ___________		
Artificial Joint	Y ☐	N ☐
What Joint: ____________		
When: ________________		
Asthma	Y ☐	N ☐
Blood Disease	Y ☐	N ☐
Blood Transfusion	Y ☐	N ☐
Breath Problems	Y ☐	N ☐
Bruise Easily	Y ☐	N ☐
Cancer	Y ☐	N ☐
Type: _________________		
When: ________________		
Chemotherapy	Y ☐	N ☐
When: ________________		
Chest Pains	Y ☐	N ☐
Cold Sores/Fever Blisters	Y ☐	N ☐
Congenital Heart Disease	Y ☐	N ☐
COPD	Y ☐	N ☐
Crohn's Disease	Y ☐	N ☐
Diabetes	Y ☐	N ☐
Type I _____ or Type II _____		
Dizziness	Y ☐	N ☐
Drug Addiction	Y ☐	N ☐
Dry Mouth	Y ☐	N ☐
Eating Disorders	Y ☐	N ☐
Emphysema	Y ☐	N ☐
Epilepsy	Y ☐	N ☐
Excessive Bleeding	Y ☐	N ☐
Frequent Cough	Y ☐	N ☐
Frequent Diarrhea	Y ☐	N ☐
Frequent Headaches	Y ☐	N ☐
Glaucoma	Y ☐	N ☐
Growths	Y ☐	N ☐
Heart Attack	Y ☐	N ☐
Heart Failure	Y ☐	N ☐
Heart Murmur	Y ☐	N ☐
Heart Disease	Y ☐	N ☐
Hemophilia	Y ☐	N ☐
Hepatitis A	Y ☐	N ☐
Hepatitis B	Y ☐	N ☐
Hepatitis C	Y ☐	N ☐
Herpes	Y ☐	N ☐
High Blood Pressure	Y ☐	N ☐
High Cholesterol	Y ☐	N ☐
Hyperglycemia	Y ☐	N ☐
Hypoglycemia	Y ☐	N ☐
Irregular Heart Beat	Y ☐	N ☐
Kidney Problems	Y ☐	N ☐
Leukemia	Y ☐	N ☐
Liver Disease	Y ☐	N ☐
Low Blood Pressure	Y ☐	N ☐
Lung Disease	Y ☐	N ☐
Mitral Valve Prolapse	Y ☐	N ☐
Osteoporosis	Y ☐	N ☐
Psychiatric Care	Y ☐	N ☐
Radiation Treatment	Y ☐	N ☐
When: ________________		
Renal Dialysis	Y ☐	N ☐
Rheumatic Fever	Y ☐	N ☐
Rheumatism	Y ☐	N ☐
Scarlet Fever	Y ☐	N ☐
Seizures	Y ☐	N ☐
Shingles	Y ☐	N ☐
Sickle Cell Disease	Y ☐	N ☐
Sinus Infections	Y ☐	N ☐
Sinus Problems	Y ☐	N ☐
Sleep Apnea	Y ☐	N ☐
Do you wear a C-PAP?	Y ☐	N ☐
Stomach Issues	Y ☐	N ☐
Stroke	Y ☐	N ☐
Swelling	Y ☐	N ☐
Thyroid Disease	Y ☐	N ☐
Tonsillitis	Y ☐	N ☐
Tuberculosis	Y ☐	N ☐
Tumors	Y ☐	N ☐
Venereal Disease	Y ☐	N ☐

Any serious illness or health problems that require further clarification not on the previous page:

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

Patient/Guardian Signature: ______________________________ **Date:** ______________

Doctor's Signature: ______________________________ **Date:** ______________

Oral Abnormality Screening Consent Form

We are very concerned about oral cancer and conduct screening examinations on every patient.

The incidence of Oral Cancer continues to rise in the USA. The American Cancer Society indicates that in 2012, they expect an increase in this deadly disease that will surpass cervical, testicular, melanoma and many other more commonly know cancers. **Alarmingly, 25% of the new oral cancer cases are people that do not have any of the traditional lifestyle risk factors such as age, tobacco and alcohol use.**

Traditionally, our dentists and hygienists have done oral cancer screening with the naked eye, but recently a new technology, the **VELscope** has received FDA approval. The **VELscope** (Visually Enhanced Lesion scope) **will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.**

VELscope, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope handpiece and the hygienist or dentist may find tissue abnormalities at an earlier stage. Before the exam the room is darkened, and much like "desert storm night vision technology," the clinician can see changes in tissue that may not be visible to the eye. These detected changes can range from something minor to something of greater concern that may require further examination and follow-up.

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. The normal fee for this procedure is $65, however, the Doctor feels so strongly that every patient has this examination at least once a year, our charge for this enhanced examination is only $25. The VELscope exam may or may not be covered by dental insurances. As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure.

Please sign the area below to accept the financial responsibility for this procedure.

Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients/

Thank you for your kind consideration.

YES, I authorize the office to perform the VELscope examination.

Print Name ______________________________

Signature ______________________________ Date ____________________

No, I decline this procedure at this time.

Print Name ______________________________

Signature ______________________________ Date ____________________

Oral Cancer Facts:

- **The fastest rate of Oral Cancer is in patients that do not smoke or drink and are below the age of 40.**
- **It is one of the easiest to treat when found early but has one of the lowest survival rates because it generally is found too late.**
- **The virus that causes cervical cancer, Human Papilloma Virus (HPV), is now believed to be a leading cause of oral cancer, making it almost everyone at risk. It is believed that the virus can be transmitted simply through kissing.**
- **African Americans, poor access to healthcare and those over 40 are at an increase risk.**

Please answer the following questions:

Have you ever had an oral cancer screening performed?	☐ Yes	☐ No
Do you regularly use sunblock to reduce sun exposure?	☐ Yes	☐ No
Do you eat a low amount of fruit and vegetables?	☐ Yes	☐ No
Have you ever had an area in your mouth that you were concerned about (sore, irritation)?	☐ Yes	☐ No
If YES, where? ______________________________		
Have you ever tested positive for HPV - Human Papillomavirus?	☐ Yes	☐ No
Have you ever smoked or used chew tobacco?	☐ Yes	☐ No
How many alcohol drinks per week? ☐ 0-5 ☐ 5-10 ☐ 15+		
Have you ever had a Pap smear, mommogram or PSA performed?	☐ Yes	☐ No
For female patients:		
Have you ever had a positive cervical Pap smear?	☐ Yes	☐ No

Name: ______________________________ **Date:** ______________

Enhanced Oral Assessment

Please read:

Blood thinners are taken to prevent the formation of blood clots and reduce the risk of heart attack, stroke, and pulmonary embolism. Blood thinners do not make your blood thinner. Nor can they break up clots. But they do keep blood from forming *new clots*. They can also slow the growth of existing ones.

People who take blood thinners are at an increased risk of excessive bleeding. If they cut themselves, it may take longer for the bleeding to stop. Sometimes, bleeding may require medical attention. Some dental treatments are ***surgical*** **procedures** which can cause *excessive* bleeding. Before major treatment is done it is required for the patient to have instruction and permission *from the prescribing doctor* to pause blood thinner medications for a period before and/or after dental treatment.

It is important for Dr. Campbell to know if you are taking a blood thinner currently or if you start one at any point under his care. Please inform any member of our staff if you are involved with a blood thinner so we can treat you safely.

Are you on a blood thinner? Yes or No

Name of medication: ______________________________

Patient signature: __________________________________ Date:__________