Patient Concerns

Name: _____ **Date:** _____

We understand that every patient is unique. Therefore, in an effort to treat you in the best way, please check off below any that may apply to you. If none apply, check off "None above apply to me".

- ❑ I gag easily
- ❑ I feel out of control during dental treatment
- ❑ I get dizzy if I lie back too far.
- ❑ I am uncomfortable while suctioning is taking place.
- ❑ Sometimes the water goes down my throat and I choke
- ❑ My teeth are sensitive
- ❑ I don't like the sound of the tool that makes the picking and scraping noise
- ❑ I don't like the feel of cotton rolls in my mouth
- ❑ I hate the sound of the drill
- ❑ My mouth always seems dry
- ❑ I haven't been to the dentist in a long time, and I'm afraid what you might say about my teeth and dental condition
- ❑ Pain relief is a top priority
- ❑ I don't like shots or I've had a bad experience with them
- ❑ I have difficulty listening and then remembering what I've heard while sitting in a dental chair.
- ❑ I'm uncomfortable being lectured
- ❑ I need a break during long appointments
- ❑ I'm expecting something to hurt
- ❑ I have trouble holding my mouth open for a long time
- ❑ My family doesn't receive regular dental care
- ❑ I like to do research when presented with a dental/medical problem/condition/recommendation
- ❑ It is difficult for me to find time to schedule dental appointments
- ❑ It is difficult for me to keep from canceling appointments at the last minute because my schedule changes
- ❑ I am worried about how much treatment will cost
- ❑ I can only afford treatment that is covered by insurance
- ❑ I'm worried that I won't qualify for financing
- ❑ **NONE ABOVE APPLY TO ME**

My fear of a toothache is

❑Extremely High ❑High ❑Medium ❑Low

Please check off your top 3 concerns from the list below:

- ❑ Discolored or stained teeth
- ❑ Yellow teeth
- ❑ Gray edges of teeth
- ❑ Short or worn teeth
- ❑ Receding gums that make my teeth look too long
- ❑ My teeth are too big
- ❑ Crooked teeth
- ❑ My teeth make me look older than I am
- ❑ Different colored teeth
- ❑ Sunken in cheeks due to tooth loss
- ❑ Wrinkles around my lips
- ❑ My lower or upper jaw juts out too far
- ❑ Spaces between my teeth
- ❑ Black triangles between my teeth
- ❑ Bleeding gums
- ❑ Being seen with cracked or broken teeth
- ❑ Being seen with no teeth
- ❑ Being seen with a missing tooth
- ❑ Blackening teeth
- ❑ Embarrassment while kissing
- ❑ Being perceived negatively by people
- ❑ Bad breath
- ❑ I'm afraid I'll end up with dentures
- ❑ Dentures causing lisping or clacking
- ❑ Dentures falling out in public
- ❑ Having to put my teeth in a glass by the bed
- ❑ I don't like the way my teeth look in photos
- ❑ I am envious of others who have a beautiful smile
- ❑ I'm embarrassed by my smile
- ❑ I usually cover my mouth when I smile
- ❑ I'm worried about not being able to chew
- ❑ My enjoyment of eating may disappear
- ❑ It may become difficult for me to eat
- ❑ I get food stuck in between my teeth
- ❑ My health may be negatively affected or made worse by my dental condition
- ❑ I'm worried I'll get a terrible toothache so painful I can't stand it

- ❑ **NONE ABOVE APPLY TO ME**

Patient Registration

Name: _____
Mr, Mrs, Ms, Dr. First Last

Home Address: _____Apt/Condo: ____ City: _____State: ____ Zip: _____
Home Phone: _____Cell Phone: _____Work Phone: _____Ext: _____
E-mail: _____If we need to reach you during the day, which number should we call? _____
Birthdate: _____ Age: _____ ☐Male ☐ Female SS#:_____

Your Employer: _____Work Address: _____
Spouse/Roommate Information: Name: _____ Phone: _____ Relationship: _____
Person Responsible for Account, if different from patient: Name: _____ Phone: _____
Relationship: _____ SS#:_____ Billing Address if different from patient: _____
In the event of an emergency, whom should we contact? Name: _____Relationship:_____ Phone: _____
How did you hear about us? : _____ If referred, by whom? :_____
Availability: Can you **come** in on short notice? _____ Best Day of week for Appointments _____Worst:_____
Best Time of Day: _____Worst:_____ Appointments only on these days:_____
Preferred Pharmacy: _____Phone #:_____Address: _____

HIPPA NOTICE OF PRIVACY PRACTICES

The following describes how medical information about you may be used and disclosed and how you can get access to this information. **To Provide Treatment -** We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment. **To Obtain Payment -** We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information. **To Conduct Health Care Operations** - Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities. **In Patient Reminders -** Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders). **Business Associates** - We may disclose the minimum necessary amount of protected health information to a business associate or allow the business associate to create or receive your information on our behalf only if the business associate has agreed in writing to appropriately safeguard it. For example, our software and computer technicians may inadvertently view information when they need to correct a problem. **Marketing** - Our office will obtain written authorization from you if we would like to use you health information for marketing purposes, except for fact-to-face communications or a promotional gift of nominal value provided to you while visiting this office. You have the right to revoke this authorization as long as you do so in writing. **Abuse or Neglect** - We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement. **Public Health and National Security** - We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device. I affirm that the information I have given today is correct to the best of my knowledge. I have read and understood the Notice of Privacy Practice above. It is my responsibility to inform this office of any changes in my status or contact information.

_____ _____
Patient's Signature ***Date***

RELEASE AND PHOTO IMAGE PUBLICATION CONSENT AGREEMENT

This Release and Photo Image Publication Consent Verification Agreement (AGREEMENT) is entered into between Dentistry for Life with its principal place of business at 1601 Walnut St. Ste.1217 Philadelphia, PA and _____.This AGREEMENT is for the purpose of identifying any express or implied agreement, including, but not limited to, permission, consent, release, and/or authorization between DENTIST and PATIENT in connection with the medical services PATIENT received from DENTIST, and/or DENTIST'S associates. DENTIST and PATIENT warrant and represent that PATIENT has given CONSENT and FULL AUTHORIZATION that any photographs and/or images of PATIENT and/or parts of PATIENT'S body, under the following conditions: The photographs and/or images will be taken by DENTIST or by a photographer and/or skilled operator approved by DENTIST. The photographs and/or images may be used for:

a. Medical records, and if in the judgment of DENTIST, medical research, education or science will be benefited by their use, such photographs and/or images and information relating to PATIENT may be published or republished, either separately or in connection with each other, in, but not limited to, professional journals, medical books, medical based Internet web-sites, or any other purpose which DENTIST may deem proper in the interest of, but not limited to, medical education, knowledge, or research.

b. PATIENT further authorizes that the photographs and/or images may be used by DENTIST or by any entity approved by DENTIST in promotional printed, computer web-site, and/or video material provided that patient full face is obscured.

At no time will PATIENT'S name, address, or any other alpha/numeric PATIENT-identifiable information be used in connection with the publication of the photographs and/or images of PATIENT. PATIENT acknowledges the possibility that his/her identity may become known as a result of the publication and use of the photographs and/or images described in paragraph 2 above. The photographs and/or images may be modified and/or retouched in any way in DENTIST'S discretion. By signing below, PATIENT certifies that he/she has read and understood each and every section of this Agreement, and agrees to be bound by its terms.

_____ _____
Patient's Signature ***Date***

Medical History

Name: _____ **Date:** _____

What is the date of your last health care exam and the reason? _____
List the names and phone numbers of all doctors you currently see and any who have treated you for anything significant in the past 5 years.
_____
List any medications you are currently taking including over the counter and supplements along with dosage.
_____
_____

Check off any of the following that you have had or have presently and mark how long ago.

- ❑Abnormal Bleeding
- ❑AIDS/ HIV
- ❑Alcohol Abuse
- ❑Allergies or Hives
- ❑Anemia
- ❑Angina
- ❑Arthritis
- ❑Artificial Valve or Pacemaker
- ❑Artificial joints
- ❑Asthma
- ❑Blood transfusion
- ❑Bruise easily
- ❑Cancer
- ❑Chemotherapy
- ❑Chronic cough
- ❑Cold Sores
- ❑Colitis
- ❑Congenital Heart Defect
- ❑Diabetes
- ❑Difficulty Breathing
- ❑Drug Addiction
- ❑Emphysema
- ❑Epilepsy or Seizures
- ❑Fainting or Dizzy Spells
- ❑Frequent Headaches
- ❑Glaucoma
- ❑Heart Disease or Attack
- ❑Heart Murmur
- ❑Heart Surgery
- ❑Hepatitis A (infectious)
- ❑Hepatitis B
- ❑Hepatitis C
- ❑High Blood Pressure
- ❑Jaundice
- ❑Kidney Trouble
- ❑Liver Disease
- ❑Low Blood Pressure
- ❑Osteoporosis
- ❑Prostheses
- ❑Psychiatric Treatment
- ❑Radiation Treatment
- ❑Rheumatic fever
- ❑Rheumatism
- ❑Scarlet Fever
- ❑Shingles
- ❑Sickle Cell
- ❑Sinus Trouble
- ❑Stroke
- ❑Thyroid Disease
- ❑TMJ
- ❑Tuberculosis
- ❑Recreational Drugs
  - What Kind? _____
  - How Often? _____

Are you allergic to anything? – Medicine of any kind – (please list), latex, metal, food, etc? _____
_____
Have you been a patient in the hospital in the last 2 years? If so, what was the reason? _____
When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath? _____
Do your ankles swell during the day? _____ Do you use more than 2 pillows to sleep? _____
Have you lost or gained more than 10 pounds in the past year? _____Do you ever wake up from sleep short of breath? _____
Are you on a special diet? If so, why? _____ Do you have any disease, condition, or problem not listed? _____
Are you pregnant or possibly could be? _____ Are You Nursing? _____ Are you using birth control? _____
Do You Smoke or use Tobacco in any form? _____ How many packs per day? _____ Per week? _____ Per Month? _____

Dental History Health Risks Associated with Gum Infection - Periodontal Disease is a serious bacterial infection that tends to "run in families". Please answer the following questions to determine if you are an At Risk Patient. **Heart Problems –** Gum infection has been tied to heart disease and stroke. Please check below if a **family member** has ever had any of the following:

- ❑Heart Murmur
- ❑Heart Attack
- ❑Cardiovascular Disease
- ❑Congenital Heart Defect
- ❑Pace Maker or Artificial Valve
- ❑Congestive Heart Failure
- ❑Chest Pains on Exertion
- ❑Circulatory Problems
- ❑Elevated Triglycerides
- ❑High Cholesterol
- ❑High Blood Pressure
- ❑Heart Valve Damage
- ❑Rheumatic Fever
- ❑Overweight & Sedentary
- ❑Fainting or Dizziness
- ❑High Fat Diet
- ❑Stroke

Other Medical Problems – Gum infection is also tied to other medical and dental conditions. Please check below if a **family member** has ever had the following:

- ❑Alzheimer's
- ❑Arthritis/Rheumatism
- ❑Osteoporosis
- ❑Cancer
- ❑Leukemia
- ❑Chemotherapy
- ❑Diabetes
- ❑Extreme Tooth Loss
- ❑Hypoglycemia
- ❑Lung Infections
- ❑Respiratory Infections
- ❑Premature Birth
- ❑Low Birth Weight babies
- ❑Bad Breath
- ❑Premature Death
- ❑Asthma/Emphysema
- ❑Pneumonia
- ❑Ulcers
- ❑Joint Replacement
- ❑Organ or Bone Marrow Transplant
- ❑Weak Immune System
- ❑Bleeding Gums

Previous dentist's name: _____ When was the last time you saw a dentist? _____
What for? _____ What was recommended? _____ Did you follow through? _____
If not, why? _____ How often do you have your teeth professionally cleaned? _____
Have you ever had gum disease? _____ If so, was it treated? _____ Do your gums bleed?_____ How do you take care of your teeth and gums at home? _____ Have you ever had a negative experience or been dissatisfied with a dentist or hygienist? _____
If so, please explain: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medicines change, I will inform the dentist at the next appointment without fail.

_____ _____
Patient's Signature *Date*

Insurance & Financial Policies

Name: _____ **Date:** _____

Your dental insurance is made available to you through your company, union, or an association, and occasionally you may purchase it on your own. **YOU** are therefore the subscriber and as such, **YOU** have a contract with the insurance company. You or your group pays the insurance company a monthly "premium" for which they give you certain benefits, which vary considerably from one plan to the next, even within the same employer. WE have no contract with your insurance company. Our responsibility is to you alone. We are committed to giving you the best dental care available. **As a courtesy to you, we agree to** file claims for you, accept assignment of benefits (your insurance company will send the "benefit" amount they owe you directly to us) provided you have on file a valid credit card & permission slip. **In return, you agree to** accept financial responsibility for the entire cost of the treatment, pay your estimated co-pay at the time of treatment, and keep a valid credit card & permission slip on file with us.

I understand that my dental insurance, _____ is OUT OF NETWORK with Dentistry for Life, therefore, I accept all financial responsibilities.

_____ _____

Patient's Signature ***Date***

How does the co-pay work? At the time of service, you only pay the **estimated** amount not covered by your insurance. Why do we have to estimate? Most insurance plans pay benefits based on a schedule of fees arbitrarily set by THEM. For example: if your plan states it will pay you 80% of the cost of dental treatments, it means 80% of THEIR fee schedule, not the actual fee charged by us. Since most insurance companies keep their fee schedules secret, we can only estimate what they will cover leaving you responsible for the difference. If you believe the dental benefits provided by your plan are inadequate, you may want to discuss the matter with your employer, union or association.

Primary Insurance Information: Insurance Company's Name: _____ Ins. Co. Address: _____
Ins. Co. Phone: _____ Group, Plan, Local, or Policy #_____Insured's Name:_____
Insured's Birthdate_____ SS#_____ Employer_____

Dentistry for Life accepts several forms of payment for dental treatment including ***cash, credit card, debit card, personal check, and business check*** (by an authorized person). Payment is required prior to major treatment and at the time of service for minor treatment and preventive care. **We do not bill. If your appointment is over 2 hours, a deposit is required to reserve that time. You have an option to make a deposit of 15% of the total cost OR $100 per hour, once deposit is made, we can reserve your appointment. The remaining balance is due on your reserved appointment.**

Extended Payment Plans: If you prefer not to use or don't have a credit card or cash, we recommend that you apply for one of our outside financing plans. These companies can provide financing for as little as $150 up to $30,000 with terms ranging from 3 months to 5 yrs. You must apply and qualify for these plans. The Office Manager will review these with you during your financial consultation.

Cancellation Policy: Dentistry for Life DOES NOT DOUBLE BOOK APPOINTMENTS, your time is reserved with the doctor and/or hygienist. Appointments that are missed, cancelled, or rescheduled without 2 full working days notice are a burden to other patients who can't get in because the appointment book appears full and because they increase costs for everyone. Consequently, the following policy is designed to protect our conscientious patients: **1st time: Emergencies Happen: Policy Reminder – 2nd time: Deposit of $25 per half hour required to reschedule. Deposit is refundable when appt. is kept. – 3rd time: Deposit of $50 per half hour of appt. time required to reschedule. 4th time: You may not schedule appointments in advance, but will need to call same day or we will call you. – 5th time: You will be dismissed from the practice.**

_____ _____

Patient's Signature ***Date***

Past due Account Balance: I understand that I may incur a 1.5% or 18% (or whatever the state of Pennsylvania allows) finance charge if my balance goes beyond 60 days. Also I understand that I will incur a $5 late fee for any balances beyond 60 days. I hereby authorize Dentistry for Life to release to my insurance company, information acquired in the course of my dental care and to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I hereby authorize benefits to be paid directly to Dentistry for Life. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this Assignment shall be considered as effective and valid as the original. I understand I am responsible for any unpaid balances & I authorize Dentistry for Life to charge my credit card with any unpaid balances 60 days after treatment has been rendered unless I have made other arrangements. I understand that treatment cannot be completed until it is paid for (i.e. crowns will not be cemented, dentures will not be placed). I understand that if I do not have a credit card authorization on file, it will be necessary for me to have an open account with a financing company on which Dentistry For Life can charge any balances not paid within 60 days. *(If you cannot meet these requirements, you will have to pay the entire amount due at the time of service & the insurance check will go to you. We will still file your claims but all follow-up will be your responsibility).*

_____ _____

Patient's Signature ***Date***

PRE-AUTHORIZED CREDIT/DEBIT CARD: In order to charge your credit card without having the card present, we are required to get this signed pre-authorization. Rest assured that this information is secure and no one other than the office manager will ever have access to it. It is kept on a secure bank server. There is no copy of your card kept in our office. Your card will never be used without your prior verbal permission for anything other than below unless we cannot get in touch with you and you have an outstanding balance beyond 60 days. Consequently, it is important that you keep your contact information up-to-date. **I authorize Dentistry for Life to keep my signature on file and to charge my:**
___VISA ___MASTERCARD ___AMEX ___DISCOVER
1) Credit card payments by phone as directed by me. 2) Balance of charges not paid by insurance within 60 days and not to exceed $_____
3) Any fees charged for appointments missed, cancelled, or rescheduled with less than 2 full working days notice not to exceed $500.
4) Deposits in amounts specified by me to hold appointments unless I have made other payment arrangements.
5) Recurring charges (ongoing treatments) of $_____ every _____ from_____ to _____
I understand that this form is valid for one year unless I cancel the authorization through written notice to Dentistry for Life
CARD HOLDER NAME _____
CITY **STATE** **ZIP**

_____ _____ _____ _____

Last 4 Digits of CREDIT CARD **EXPIRATION DATE** **CARD HOLDER SIGNATURE** **DATE**

CONSENT TO TREAT

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment listed below. I understand my dental condition and have discussed several treatment options with the undersigned provider. I have been given a printed copy of the procedure or treatment details and any post-op instructions.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed below. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I authorize any necessary life-saving procedures to be performed in the event of an emergency during the procedure(s) or course(s) of treatment. I understand that a blood transfusion may be a part of a life-saving procedure and give my consent for necessary blood work. I give my consent for the administration of any medication that may be required as a life-saving measure.

I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider.

I confirm that I understand this form and the information contained therein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

Print Name:_____

Signature Name:_____

Date: _____

Oral Cancer Screening **Name:** _____ **Date:** _____

CONSENT FORM ORAL CANCER SCREENING

COMPLETE FOR EACH PATIENT AND PLACE IN RECORDS OF PATIENT.

In our practice, as your healthcare provider, we seek to provide you access to the newest and most effective scientific screening and treatment. In 2009 the StarDental® Identafi® system was introduced. This multispectral medical device greatly enhances our ability to find early signs of cancer and dysplasia in the mouth. Historically our practice has used white light in examination for oral cancer. The use of narrow band violet light and green amber reflected light helps us detect in the oral tissue various problems including cancer lesions and dysplasia.

Early detection of oral cancer is important to being able to provide early treatment and avoidance of the problems which arise from late stage detection of oral cancer. We encourage you to discuss with us your questions related to detection of oral cancer.

The Oral Cancer Foundation advises that 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. Recently scientists have established a connection between HPV viral infection in the mouth and the occurrence of oral cancer.

Yes. I request that the clinician perform the StarDental Identafi examination. I accept financial responsibility for this examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have this examination at this time.

Print name: _____

Signature: _____ Date: _____

HENRY SCHEIN DENTAL

www.identafi.net

StarDental DentalEZ

DTIN LM 127