# New Patient Information

Today's Date _____ /_____ /_____

| | | |
|---|---|---|
| Patient's Name: | | |
| Street Address: | | |
| | State: | Zip Code: |
| Home Phone: | Work Phone: | |
| Cell Phone: | SSN: | |
| Date of Birth: ____ / ____ / _____ | E-Mail Address: | |
| Name of Person Responsible for This Account: | | |

Do You Have Dental Insurance: YES NO

| | |
|---|---|
| Policy Holder's Name: | |
| Policy Holder's DOB: | Policy Holder's SSN: |
| Name of Insurance Company: | |
| Name of Employer Insurance is Through: | |

Emergency Contact Information:

| | |
|---|---|
| Name and Relationship to Patient: | |
| Phone Number: | |

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

| | |
|---|---|
| Name: | Relationship: |
| Name: | Relationship: |
| Name: | Relationship: |

Please list any specific questions or areas of concern you have about your oral health:

How long has it been since you were seen by a dentist?

Whom may we thank for referring you to our office?

Dental SOLUTIONS

# 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. 35,000 new cases of oral cancer are diagnosed each year. The 5 year survival rate is only 50%. With early detection, you have a much better chance of surviving oral cancer. That is why we recommend anyone 15 years of age and older, be screened annually.

Risk factors for developing oral cancer include: smoking, chewing tobacco, alcohol consumption, and some strains of Human Papillomavirus (HPV). HPV is an increasingly common virus with approximately 6 million new cases per year.

We want to partner with you in beating cancer and keeping you healthy. In order to do that, we are now offering HPV screenings for the mouth and ViziLite Plus oral cancer screening that allows us to catch cancer at its earliest stages.

## Please Complete the Following

_____ Yes, please test me for cancer causing HPV ($165)

_____ Yes, please include the ViziLite Plus screening with my exam today ($50)

_____ No, I am declining these potentially lifesaving tests at this time. I prefer a visual exam only.

Patient Name: _____ Date: _____

Signature of Patient, Parent of Guardian: _____

# Office Policies

Please read this form carefully. Should you have any questions, our office coordinators will be delighted to help you.

Please Check All Boxes

## Appointments & Deposits:

☐ At Dental Solutions we consider the appointment the confirmation. Although we may send you reminders, by setting the appointment we are making a commitment to block a portion of time specifically for you and making it unavailable for other patients.

☐ As a courtesy, please notify Dental Solutions if you cannot make your appointment at least 24 hours prior to the scheduled time. Missed or late cancelled appointments may be subject o a fee of $50 per hour scheduled.

☐ Appointments for treatment that require more than two (2) hours will require a deposit of 50% of the patient portion to secure the appointment.

## Dental Insurance:

☐ For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement on your behalf.

☐ Your insurance is a contract between you and your insurance company. Dental Solutions is NOT a part of that contract.

☐ Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select services they will and will not cover.

☐ We are an amalgam (mercury) free office. If your insurance only pays for the alternate amalgam fee, then you are responsible for the non-covered difference in the fee.

☐ If your insurance carrier does not pay the estimated benefit in full, you will be immediately responsible for any remaining balance.

☐ If we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

## Financial Policy:

☐ Full payment is due at the time of service.

☐ Forms of payment we accept:

- Cash
- Check
    - If a check is returned unpaid, there will be a $35.00 charge and checks will no longer be accepted.
- Credit Cards (Visa, Mastercard, Discover)
- Care Credit (10% Fee)

## Payment & Collections:

☐ Patient acknowledges and agrees that all accounts past 30 days shall bear a compounding interest rate of 1.5% per month. In the event that a patient does not pay for performed services, Dental Solutions, may place patient's account with a collection agency. Patient further agrees to pay reasonable collection fees.

## General Consent Form

☐ I hereby authorize and direct the dentists of Dental Solutions and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

☐ In general terms, the dental procedure(s) can include but not be limited to:

a. Comprehensive oral examination, x-rays, cleaning of the teeth, and application of topical fluoride.
b. Application of plastic "sealants" to the grooves of teeth.
c. Treatment of diseased or injured teeth with dental restorations (fillings).
d. Placement of space maintainers and/or replacement of missing teeth with dental prosthesis.
e. Treatment of diseased or injured oral tissues secondary to traumatic injuries and/or accidents and/or infections.
f. Oral surgery, extractions (removal), root canal, crowns, bridges and orthodontic treatment are a few treatments that require additional consent forms.

☐ I understand that the doctor is not responsible for previous dental treatment. I understand that, in the course of treatment, this previously existing dentistry may need adjustments and/or replacement.

☐ I authorize the dentists of Dental Solutions, to forward a review of finds and/or any other dental information to the referring doctor (if such has been the referral source) or any other health care giver for his/her records, as well as any third parties such as insurance companies who may request information.

☐ I authorize Dental Solutions to take photographs, x-rays, and/or videos of my face, jaws, and teeth as a record of my care.

☐ I authorize Dental Solutions to use photos of a non-clinical nature for their website or social media with the following exceptions:

_____ I do not wish to have my first name show or released

_____ I do not wish to have my entire face shown

_____ I only agree to have my teeth shown without any identifying features

I do not expect compensation, financial or otherwise, for the use of these photographs.

## Responsible Party:

As the responsible party, in the case where my spouse and/or children are also patients at Dental Solutions, signing this Office Policies form will apply to them and their accounts as well.

_____ _____

Signature of Responsible Party Date

_____

Print Name of Responsible Party

**Dental Solutions**

**ACKNOWLEDGEMENT OF RECEIPT OF**
**HIPAA NOTICE OF PRIVACY PRACTICES**
**("Acknowledgement")**

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

**Please Note: It is your right to refuse to sign this Acknowledgement.**

*Dental Office Use Only*

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____

_____ _____
Staff Member Signature Date