THANK YOU FOR CHOOSING ADVANCED DENTAL CARE

Welcome to our office. We appreciate the confidence you have placed with us to provide Dental care. All information on this chart is necessary for our records and is strictly confidential.

PATIENT NAME (FIRST / LAST / M.I.) _____ D.O.B. _____

ADDRESS (STREET) _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (___) _____ CELL: (___) _____

WORK PHONE (___) _____ EMAIL: _____

SOCIAL SECURITY # _____ EMPLOYER _____

POLICY HOLDER INFORMATION

NAME: _____ SSN: _____ INSURANCE COMPANY _____

EMERGENCY CONTACT _____ PHONE _____

PLEASE LET US KNOW HOW YOU HEARD ABOUT

- ☐ FRIEND/RELATIVE _____
- ☐ WEBSITE _____
- ☐ OTHER _____
- ☐ SIGNAGE
- ☐ ADVERTISING
- ☐ YELLOW PAGES SPRINT/BELLSOUTH
- ☐ INSURANCE COMPANY

DENTAL HEALTH HISTORY

The information you provide is important for your dental health. If there have been any changes in your health, **please tell us.** If you have any questions, do not hesitate to ask. **Please answer Yes or No** to the following questions:

	Yes	No
Are you having any discomfort?	☐	☐
Any sensitivity to hot, cold, sweets, chewing?	☐	☐
Does dental treatment make you nervous?	☐	☐
Are your teeth turning yellow or losing brightness?	☐	☐
Do you smoke?	☐	☐
Do you drink coffee or tea?	☐	☐

Have you experienced any of the following problems?

	Yes	No
Snoring problem	☐	☐
Bleeding gums	☐	☐
Bad breath	☐	☐
Grinding of teeth	☐	☐
Mouth guard for athletes	☐	☐

If I could change my smile I would make my teeth:

	Yes	No
Whiter	☐	☐
Close space	☐	☐
Replace stained front filling	☐	☐
Change silver filling to white	☐	☐
Repair chipped teeth	☐	☐

Other _____

Do you have difficulty brushing your teeth due to the following:

	Yes	No
Arthritis	☐	☐
Difficulty in reaching back teeth	☐	☐
Uncontrolled hand movement	☐	☐

Other _____

	Yes	No
Do you take fluoride supplement?	☐	☐
Do you prefer to save your teeth?	☐	☐
Have you had a special coating applied to your back teeth to protect from tooth decay?	☐	☐

Date of last cleaning _____

Have you ever had Periodontal Therapy done? ☐ Yes ☐ No

Denture and Partial Patients:

	Yes	No
Do you wear a denture/partial?	☐	☐
How old is your denture/partial? _____		
Have you relined your dentures before?	☐	☐
Does your denture cause any irritation/soreness?	☐	☐
Have your dentures ever broken or cracked?	☐	☐
If you wear a partial, did you ever break a clasp?	☐	☐
Do you use denture cleaner?	☐	☐
Do you use any product to prevent denture odor?	☐	☐
Are your dentures loose?	☐	☐
Do you use any denture adhesive?	☐	☐

What would you change about your denture/partial appearance?

_____

_____

Please explain reason for your visit today. _____

_____

_____

Medical Alert

Please complete back

MEDICAL HEALTH HISTORY

Name of physician _____ Physician's phone # _____

Name of previous dentist _____ Reason for leaving _____

Date of last visit to physician _____ _____

Do you have or have you had, any of the following? Please answer Yes or No or explain.

	Yes	No
Heart Problems		
Chest Pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Other _____		
Blood Problems		
Easy bruising	☐	☐
Frequent nose bleeding	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Other _____		
Allergy Problems		
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Other _____		
Intestinal Problems		
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation	☐	☐
Other _____		
Bone or Joint Problems		
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip)	☐	☐
Pins or Metal Rods	☐	☐
Other _____		

	Yes	No
Fainting Spells, Seizures, or Epilepsy	☐	☐
Diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Cancer/Tumor, Chemotherapy, X-Ray Treatments or IV Bisphosphonate Treatment (e.g. Fosamax, Zometa or Aredia)	☐	☐
Hepatitis, Jaundice, or Liver Trouble	☐	☐
Herpes	☐	☐
HIV-Positive/AIDS	☐	☐
Glaucoma	☐	☐
Have you been hospitalized during the past 5 years?	☐	☐
Do you have any disease, problem or condition not listed?	☐	☐
Do you have any psychiatric problems?	☐	☐
During the past 12 months have you taken any of the following?		
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizer	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin (Daily)	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerine	☐	☐
Cortisone (steroids)	☐	☐
List meds you take every day		
Other _____		
Other _____		
Other _____		

Are you allergic or have you reacted adversely to any of the following:

Local anesthetics ('Novocaine')	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Other _____		
Other _____		
Other _____		

Woman

	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: _____		

REMARK: DOCTOR USE

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

Advanced Dental Care of Winter Springs
Office and Financial Policies

Thank you for choosing us as your dental healthcare provider. We are committed to providing you with the best possible dental care. In order to understand our payment policy, please read this carefully and sign below. Feel free to ask any questions you might have before signing this form.

• Full payment is due at the time of service for non-insurance patients. We accept cash, Visa, and MasterCard. Established patients may also pay by check. Returned checks are subject to a $25 returned check charge.

• We accept assignment of benefits on selected insurance plans as a courtesy to our patients. However, payment of the estimated patient portion or any amount not covered by insurance is due in full at the time of service. Upon your request, we are happy to pre-determine your individual benefits prior to treatment being done.

• Patients will be responsible for any fees remaining if their insurance has not paid on a claim within 60 days.

• If collections become necessary, the patient will be responsible for all collection costs and attorney fees.

• We cannot directly provide financing for treatment. However, we work with Lending Club who can provide you up to 6 months interest free financing to help you receive the treatment you need today. If you are interested please let us know and we will assist you in applying for Lending Club.

• Minors must be accompanied by a parent or legal guardian who must remain in the office during treatment to consent to treatment, changes in treatment, or in cases of emergency. Our staff cannot provide a babysitting service.

• All appointments must be confirmed no later than 24 hours prior to the appointment time. All appointments which are not confirmed will be subject to cancellation.

• Appointment cancellations should be made 48 hours in advance. **Appointments cancelled short notice, for non emergency reasons, will be subject to a $50 per hour broken appointment charge. Repeated late cancellations or broken appointments will result in dismissal from the practice.**

• We make our best efforts to respect your time by staying on schedule. Please help us to do this by arriving on time to your appointment and promptly notifying us of any delays. If you are late for your appointment and we do not have adequate time left for your procedure your appointment will be rescheduled. Repeated late appointments will result in dismissal from the practice as they are disruptive to our schedule.

I have read the financial and office policies. I understand and agree to comply with these policies.

_____ _____

Signature of Patient or Responsible Party Date

<u>For Electronic Claims Filing of Dental Insurance</u>

I authorize payment of my insurance benefits, otherwise payable to me, to be made directly to the dentist. I also authorize the release of any information relative to my dental insurance claims.

_____ _____

Signature of Patient or Responsible Party Date

Advanced Dental Care of Winter Springs
HIPPA Privacy Form

This form protects your health information. We encourage you to read it thoroughly. At no time do we ever sell or give away any of our patient's personal information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information..

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kristina Wayman Phone: (407)696-6700

Address: 5659 Red Bug Lake Rd. Winter Springs, FL 32708 Fax #: (407)696-6633

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by someone other than the patient, please complete the following:

Printed name of person completing form: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Pre-Authorized Credit Card On File
(Insurance patients only)

Due to insurance limitations and exclusions, it is not always possible to determine the exact amount of a patient's co-pay/portion at the time of service. Therefore, we find that there is a remaining balance on some accounts after insurance has paid. We want to continue to offer our patients the convenience of filing their insurance to reimburse us, but at the same time, it is necessary to keep our accounts as current as possible.

In order to accomplish this we are requesting that all patients who would like to use insurance to pay for their dental treatment leave a Visa or MasterCard on file. By doing this we can still provide a convenient service for our patients, and be assured that any balance will be cleared at the completion of treatment. If you prefer to be notified before a charge is placed on your credit card please notify us and we will be happy to accommodate your request. However, please be aware that your card will be charged if all attempts to reach fail.

If you do not wish to leave your credit card on file, any outstanding balance not covered by insurance is to be paid within 30 days of insurance payment. If your account is not promptly paid we may, at our discretion, no longer accept assignment of benefits of your insurance. **This would mean that all future visits would need to be paid in full at the time of your visit and we would submit for your insurance to reimburse you.**

Thank you for your understanding in this matter.

_____

Cardholder's Name

_____

Credit Card Number Expiration Date

_____

Cardholder's Signature Card Type

_____

Authorized User V-Code Billing Zip Code

_____

Additional Patients you would like this card used for

I do not wish to leave a credit card on file. I prefer to be billed instead. I understand that any past due balance may result in pre-payment in full for all future appointments as outlined in this form.

_____

Signature of Patient or Responsible Party

Oral Cancer Screening Consent

Our practice continually strives to provide important enhancements in oral health care for our patients. In 2009 Trimira LLC introduced the Identafi 3000, a multispectral medical device, which greatly enhances our ability to find early signs of cancer in the mouth. We find that using this device greatly improves our ability to identify suspicious areas that may have been missed during a conventional exam.

The Oral Cancer Foundation advises that one American dies every hour from Oral Cancer. Early detection of oral cancer and pre cancerous tissue can minimize or eliminate the potentially disfiguring effect of oral cancer and possibly save your life. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase.

Risk factors for oral cancer include:

- Age
- Tobacco Use
- Alcohol Consumption
- Oral HPV infection
- **25% of oral cancers occur in people who don't smoke and have no other risk factors**

Please be informed, you are still at risk for oral cancer if you are young, a non-smoker, or a non-drinker as many oral cancers stem from an HPV infection. The CDC estimates as many as 80% of Americans will be infected with a form HPV at some point in their lives. There is no way of telling if you have one of the 9 types of HPV that cause oral cancer. The CDC recommends an annual oral cancer screening with your dentist. This screening is highly important, since you will not likely notice any visible or painful symptoms when oral cancers are in their early stages of development. Oral cancer needs to be detected early as it is very unforgiving of any delay in discovery and diagnosis.

The ADA has recently provided a procedure code (D0431) for the examination described above. This code represents progress in the recognition for improved examination but does not insure that your insurance will cover this exam. The fee for this enhanced exam is $40.

Yes. I authorize that Dr. Young perform the Identafi 3000 examination. I accept financial responsibility for this examination.

Print Name: _____

Signature: _____ Date: _____

No. I have been **informed of the risks of oral cancer and the benefits of this exam yet I would prefer not to have this examination at this** time.

Print Name: _____

Signature: _____ Date: _____