(Please be completely honest. We respect total confidentiality.)

Personal Information

Name: Last: First: M.I.:

What name shall we call you? Sex:

Date of Birth: Place:

E-mail Address:

Home Phone(s): Cell Phone:

Home Address:

(Street) (Apt.#)

(City) (Zip)

Drivers License # : Social Security # :

Employer: Occupation:

Work Address & Tel # :

Name of person responsible for account:

Billing Address (if different than above):

Spouse Name: Spouse Work Phone:

Parent/Guardian Name (If patient is minor):

Person to contact in case of emergency:

Relation: Phone:

Do you have dental insurance?

Reason for visit?

Who may we thank for referring you?

I hereby authorize the doctor to take radiographs, photographs, study models or any other diagnostic aids deemed appropriate by the doctor and agreed upon, to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of therapy that may be indicated and agreed upon.

I further authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitation of billing and reimbursement directly to the dentist of insurance benefits under which I am entitled. I understand that responsibility of payment for dental services provided in this office for my dependants or me is mine, due and payable at the time services are rendered, unless other arrangements have been made with the doctor.

If you must change a scheduled appointment, please inform us as soon as possible. If we are not notified by 3 p.m., the working day prior to the appointment, then we may regrettably, charge your account.

Signature of patient or responsible party: **Date:**

Confidential Health Questionnaire

Please circle the appropriate answer

Do you smoke? If yes, how much? _____ Yes / No

Have you been treated by a physician within the past year? Yes / No

Have you ever been hospitalized or had an operation? If yes, explain: ____ Yes / No

_____

_____ Yes / No

Have you been taking any medications, including aspirin or oral contraceptives within the past year? If yes, List: _____

_____

_____

Do you have difficulty breathing when lying flat? Yes / No

Have you had radiation therapy to your head or neck? Yes / No

Do you have any artifical joints, heart valves, pacemaker, etc? Yes / No

Have you ever taken cortisone for a prolonged period? Yes / No

Do you fall into a high-risk group for acquiring and transmitting infection? (Medical and dental personnel, sexual activity, intravenous drug use) Yes / No

Are you now pregnant? Breast feeding? Yes / No

Do you or your family have a history of prolonged bleeding? Yes / No

Have you ever taken weight loss pills, such as:

Pondimin, Fastin, Redux or Fen-Phen? Yes / No

Do you now have or have you ever had, any of the following:

Heart Disease	Yes / No	High/Low Blood Pressure	Yes / No
Heart murmur	Yes / No	Kidney Disease/Infection	Yes / No
Tuberculosis	Yes / No	Skin rash/Hives	Yes / No
Diabetes	Yes / No	Rheumatic Fever	Yes / No
Aids/HIV	Yes / No	Jaw Joint (TMJ) Problem	Yes / No
Easy bruising	Yes / No	Tendency to Faint	Yes / No
Epilepsy/Seizures	Yes / No	Liver Disease/Hepatitis	Yes / No
Cancer	Yes / No	Blood Transfusion	Yes / No
Ulcers	Yes / No	Stroke	Yes / No
Sinusitis	Yes / No	Anemia	Yes / No
Allergies	Yes / No	Asthma/Bronchitis	Yes / No

Have you ever had an unusual reaction to any of the Following:

Penicillin	Yes / No	Sleeping Pills/Valium	Yes / No
Aspirin	Yes / No	Dental Injections	Yes / No
Rubber/Latex	Yes / No	Codeine	Yes / No

Others? _____

Remarks? _____

_____

******Please note that it is your responsibility to inform the doctor of any changes in your medical status during the course of treatment.***

Signature: _____ Date: _____

DDS

HEALTHY SMILES FAMILY AND COSMETIC DENTISTRY

DR. MAGGIE MICHAEL

NOTICE OF PRIVACY 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 multiply 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 have received, read and understand 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 to obtain a current copy of the *Notice of Private 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 request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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.** Studies also suggest that human papillomavirus (HPV 16/18) plays a role in more than 20% of oral cancer cases.* 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 (ages 18-39, 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 65.00 .

No. I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____

VLP004 – 2/06

* J Natl Cancer Inst 2003 Dec 3;95(23):1772-83