**Patient Information**

**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent or Guardian Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Drivers License Number**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Apartment Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cell Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **E-Mail Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First

Dental Insurance

**Company**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment

**Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Spouse Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| *I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that information is true and correct of my knowledge. I will notify you of any changes in my status or the above information.*  **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Company Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Company Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***It is important that I know about your Medical and Dental History. These facts have a direct bearing on our Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire…***

**Dental History**

**How LONG SINCE you have seen a Dentist** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Are you UNHAPPY with the APPEARANCE**

**of your teeth?** COLOR SHAPE

**Last COMPLETE Dental Exam, Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How do you feel about your teeth?** GOOD NORMAL BAD

**Last FULL MOUTH X-RAYS, Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you having PROBLEMS now?**  YES NO **Do you have LOOSE, TIPPED, SHIFTING teeth?** YES NO

Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Are your teeth all in alignment (straight)?**  YES NO

**Is your present dental health POOR?**  YES NO **Do you have any MISSING or CHIPPED teeth?** YES NO

**Do your gums BLEED, or feel TENDER or IRRITADED?**  YES NO **Do you have any frequent headaches?**  YES NO

**Are your teeth sensitive to HOT, COLD, SWEETS, Do you have any old fillings or dental work that**

**or PRESSURE?**  YES NO **you do not like?** YES NO

**Do your gums BLEED, or feel TENDER or IRRITADED?**  YES NO **Are you nervous about dental treatment?** YES NO

**What would you like to change MOST in the appearance** **What type of toothbrush do you use?** SOFT MEDIUM HARD

**of your teeth?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you use dental floss or toothpicks?**  YES NO **Is there anything about your mouth that CONCERNS you?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any swelling, sores, or blisters in your mouth?** YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you feel you have unpleasant breath at times?** YES NO

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment…

FEAR of pain \_\_\_\_\_\_\_ # LACK of concern \_\_\_\_\_\_\_ #

COST of treatment \_\_\_\_\_\_\_ # MISSING work/school time \_\_\_\_\_\_\_ #

**Do you smoke or chew tobacco?**  YES NO

**Are you aware of the new techniques in dentistry?**  YES NO

**Medical History**

**Physicians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical exam**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have, or have you had any of the following? (Please indicate with a check mark).

|  |  |  |  |
| --- | --- | --- | --- |
| * **Any heart problems** * **High blood pressure** * **Low blood pressure** * **Circulatory problems** * **Nervous problems** * **Radiation treatments** * **Excessive bleeding** * **AIDS** | * **HIV- Positive** * **Allergies to anesthetics** * **Allergies to medicines or drugs** * **Allergies to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   * **Anemia** * **Asthma** | * **Diabetes** * **Hepatitis** * **Herpes** * **Measles** * **Mumps** * **Psychiatric care** * **Rheumatic Fever** * **Malignancies** | * **Scarlet Fever** * **Sinus Problems** * **Stroke** * **Typhoid fever** * **Tonsillitis** * **Tuberculosis** * **Ulcer** * **Venereal Disease** |

**Are you or do you think you may be pregnant? YES NO Blood pressure: S \_\_\_\_\_\_\_\_\_\_\_/D\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe any medical treatment, impending operations or other medical or dental information that may possibly affect your dental treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any other known DRUG ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any CURRENT MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**$81.00**



**The Oral Cancer Problems Facing Our Society Today:**

• Oral Cancer is the 6th most common cancer in the United States.

• 30% of the people that get oral cancer have no risk factors for it.

• One American dies every hour from oral cancer.

• Oral Cancer commonly causes facial disfigurement, loss of quality of life, or death.

• All oral cancers start out as invisible to the naked eye.

• The doctor and his staff cannot see oral cancer with normal examinations until it reaches stage 3 or 4.

• Often times there are no signs or symptoms with stage 1 or 2 cancer.

• After treatment of stage 3 or stage 4 Cancer, only 50% of patients live beyond 5 years.

• The only 100% way to ensure that we’re detecting stage 1 or 2 oral cancer is to use a proven test like the VELscope Enhanced Oral Assessment.

**We offer break-through technology that detects Oral Cancer in its earliest stages and offers piece of mind for patient**

**concerned about oral cancer:**

• The VELscope exam is a simple and painless examination that will illuminate stage 1 and 2 oral cancers before they become

visible to the naked eye.

• The VELscope exam is a proven detection procedure comparable to a mammography, pap-smear, or PSA.

• Early detection of oral cancer can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life.

**The Cost:**

• This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam may not be covered by your insurance.

• MOST insurances have an insurance contracted fee for this enhanced oral assessment.

• Our office fee is $159.00. However, we offer the discounted rate of **$45.00** for NEW PATIENTS to make it more affordable and accessible.

• It could save your life, which we see as priceless.

**How it works:**

• The VELscope ®Vx Handpiece emits a safe, visible blue light into the oral cavity, which excites the oral tissue and causes it to fluoresce. The oral cavity can then be examined in real time, enhancing the practitioner’s ability to visualize suspicious tissue that may require further investigation.

•Abnormal fluorescence patterns aid the clinician in seeing unhealthy mucosal tissue that sometimes cannot be visualized with the naked eye. Such patterns may arise from a variety of causes, including:

•An increase in metabolic activity in the epithelium

• A breakdown of the fluorescent collagen cross-links in the connective tissue layer beneath the basement membrane

• An increase in tissue blood content, either from inflammation or angiogenesis (hemoglobin strongly absorbs fluorescence excitation [blue] and emission light [green])

•The presence of pigments (e.g., melanin or amalgam particles) which absorb light

**Who is at risk?**

• **Low risk:** Patients age 18-39 with no lifestyle risk factors.

• **Moderate risk:** Patients age 40 & older with no lifestyle risk factors OR patients age 18-39 with lifestyle risk factors. We recommend this exam twice a year.

• **High risk:** Patients age 40 & older with lifestyle risk factors OR previous history of cancer. We recommend this exam four a year.

• **Lifestyle risk factors include:** Tobacco use (any type, any age, within 10 years); Alcohol consumption (3 oz of hard liquor, 4 oz of wine, or 12 oz of beer); Immune deficiencies such as HIV & AIDS; Human Papilloma Virus (HPV 16/18).

***Would you like to have the VELscope Exam done today? (please check one)***

* **Yes.** I would like to have the VELscope exam done today. Based on my insurance fee schedule, I understand that I **may** have an additional cost.
* **No.** I would prefer not to have the VELscope exam at this time.

**I UNDERSTAND THAT SIGNING THIS FORM DOES NOT OBLIGATE ME TO TREATMENT.**

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Modern Dental Smiles**  **Kurt bally, d.m.d., p.a.** | |
| 4050 S. US Highway 1, Ste 322  Jupiter, Florida 33477  (561)691-6055 | 2280 N. Congress Avenue  Boynton Beach, fl 33426  (561)732-2400 |

**“PRIVACY RULE” CONSENT FORM**

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. It was also created to provide a standard for certain healthcare providers to obtain the patients’ consent to use and disclose health information to carry out treatment and insure payment.

We respect your right to the privacy of your personal dental records and will do all we can to secure and protect them. However, in some instances it may become necessary to release information to laboratories, pharmacies or other physicians in order to fulfill our commitment to maintain your health. Be assured, you have our full support to access your own records any time we are available.

By signing this consent form, you are giving us permission to release certain information for the reasons mentioned above. It also allows us to mail reminder cards addressed to you and leave messages on your voice mail regarding your appointments or account. You have the right to revoke your consent at any time with a written and signed notice.

**Print Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL BENEFIT EXPLANATION & AGREEMENT**

It is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs, and we assume that you are concerned as we are about maintaining your good health. Generally, dental benefits pay a percentage of each procedure up to a set yearly maximum. The benefits available to you are established by the plan package your employer purchased.

***As a courtesy to you, we will submit claims to your dental plan carrier. We also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion at the time services are provided.***

***\*However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We take no responsibility for any denials by dental plans\****

\_\_\_\_\_\_\_I agree to these policies regarding my dental benefits and will be held responsible for the entire balance for services rendered after 45 days of service if my dental insurance has not paid your office directly.

HYGIENE VISIT

\_\_\_\_\_\_ I understand that during my hygiene visits, Irrigation (ADA Code D9630), will be performed via an Ultrasonic Delivery Device, used to help reduce gingival inflammation and a $25.00 payment will be due at time of service

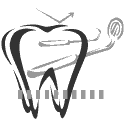
**FINANCIAL AGREEMENT FOR SELF PAY**

I acknowledge that payment is due at the time of treatment unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services or items provided to me, to my minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor child, or to the patient for whom I have legal responsibility.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of patient, parent, guardian, or personal representative Date**

Patient Confirmation Policy



Modern Dental Smiles takes patient appointments very seriously, we set aside valuable time in order to deliver the highest level of care possible, thus we like to stay well in contact with you. **We take your confirmation and appointment time very seriously.** Below are the confirmation methods that we have put in place to insure that you make it to your appointments.

* Email confirmation
* Mobile Text message confirmation
* One Week prior to appointment confirmation
* Three days prior to appointment confirmation
* One day before appointment confirmation

|  |
| --- |
| *I understand that**due to the high demand of other patient appointments, if I do not confirm my appointment* ***before 2pm the day before my appointment*** *(unless otherwise discussed with the office) my appointment may be removed from the schedule. I agree to accept all methods of confirmation stated above in our policy and certify that I will to the best of my ability confirm all appointments hence forth in a timely manner.*  **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |