WELCOME

Rancho Niguel Dental Group

Gary Mar, D.D.S.

Katie Stern, D.D.S.

Allen A. Ontiveros, D.D.S.

30140 Town Center Drive
Laguna Niguel, CA 92677
Tel: 949.249.4180
www.ranchonigueldental.com

1. ABOUT YOU

Today's Date: ____/____/____ File #____
Patient Name: _____
Last First MI
What You Prefer To Be Called: _____
Male Female
Birthdate: ____/____/____ Age: _____
SS #: _____
Preferred Language: _____
Mailing Address: _____
City: _____ State: ____ Zip: ____
Home Phone #: _____
Work Phone #: _____ Ext: ____
Cell Phone #: _____
Email: _____
Referred By: _____
Employer: _____ How long? ____
Employer's Address: _____
_____
Occupation: _____
Divorced Married Single Widowed Minor
Spouse's Name: _____
Do you have children? How many?_____

2. INSURANCE INFO

Primary Dental Insurance
Co. Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
Insured's SS#: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relation: _____ Birthdate: ____/____/____
Insured's Employer: _____

Secondary Dental Insurance
Co. Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____
Insured's SS#: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relation: _____ Birthdate: ____/____/____

3. ACCOUNT INFO

Person ultimately responsible for account
Name: _____
Relation: _____
Billing Address: _____
City: _____
State: _____ Zip: _____
SS #: _____
Driver's License #: _____
Work Phone #: _____

_____ (Initials) I here by authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

4. IN EVENT OF EMERGENCY

Whom should we contact? _____
Relation: _____
Home Phone #: _____
Work Phone #: _____
Who is your Medical Doctor? _____
M.D.'s Phone #: _____

5. DENTAL INFO

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ Yes ☐ No Length?___

Please indicate ☐ any of the following problems:

☐ Discomfort, clicking, or popping in jaw.
☐ Red, swollen or bleeding gums.
☐ Sensitive tooth, teeth, or gums.
☐ Blisters/Sores in or around the mouth.
☐ Lost/Broken filling(s)
☐ Teeth grinding
☐ Ringing in ears
☐ Broken/chipped tooth
☐ Stained teeth
☐ Locking jaw
☐ Bad breath

Other: _____

Do you require pre-medication ☐ Yes ☐ No ☐ Don't know

Previous Dentist: _____ Phone #: _____

Last Dental Exam: _____/ _____/ _____ Last Dental X-Rays: _____/ _____/ _____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile ? 1 2 3 4 5 6 7 8 9 10

6. MEDICAL HISTORY

Have you taken any medication or drugs the past two years? Yes No

Are you taking any medication, drugs, or pills now? Yes No

If yes please list name and dosage _____

Have you ever taken/do you take any of the following? (circle all that apply)

Recreational Drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisophosphonate (Fosamax)	Aspirin

Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? Yes No

If yes, please list: _____

Have you been a patient in the hospital during the past five years?

Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (surgery, disease, attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (Infectious) B (Serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artifical Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

Do you use more than two pillows to sleep?_____

Have you lost or gained more than 10 pounds in the past year?_____

Do you have or have you had any disease, condition, or problem not listed?_____

If yes, please list:_____

Women: Pregnant? Yes, ____ Months **Nursing?** Yes No **Taking birth control pills?** Yes No

I certified that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health, and/or medication. Further, I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) _____ Date _____ Signature of Doctor _____ Date _____

XII. MEDICAL UPDATES

I have reviewed my health history and confirm that it accurately states past and present conditions

Date	Patient Signature:	Changes to health history	Dentist Int

RANCHO NIGUEL DENTAL GROUP

INSURANCE AND FINANCIAL POLICY

At RANCHO NIGUEL DENTAL GROUP, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits, but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know….

Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

We currently accept all private care insurance plans and most managed care plans. This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We "estimate" your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a "Pre-Treatment Authorization" with your insurance company prior to treatment. This does delay treatment, but will give you the exact out-of-pocket figures you may require.

We bill your insurance as a "courtesy". If your insurance does not pay within 90 days, RANCHO NIGUEL DENTAL GROUP reserves the right to request payment in full for services from you, and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

RANCHO NIGUEL DENTAL GROUP does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash, and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with "Care Credit" and "Capital One", who offer a 12-month "same as cash" or longer terms with an interest-bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of our Patient Services staff for an application.

Broken Appointments: A specific amount of time is reserved for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least a 24-hour notice to avoid a $25/hour cancellation fee (emergencies are an exception).

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you have always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Print Name: _____

Signature: _____ Date: _____

4/19/07

Rancho Niguel Dental Group

30140 Town Center Drive

Laguna Niguel, CA 92677

Tel: 949-249-4180 www.ranchonigueldental.com

YOUR DENTAL APPOINTMENT

****APPOINTMENT POLICY****

Your dental appointment time is reserved specifically for you. We strongly encourage all patients to keep their appointments; however we understand situations may arise that create changes in the patient's schedule.

Please note that if you must change your appointment, Rancho Niguel Dental Group requires a 24-hour notice in order to avoid a cancellation fee of $25.00 or the contracted insurance fee. The cancellation fee covers the cost of materials ordered and prepared for your dental appointment.

Print Name_____
(Patient – Printed Name)

Signature_____
(Parent/Guardian, if minor)

Date_____

Gary Mar, D.D.S.

Katie Stern, D.D.S.

Allen A. Ontiveros, D.D.S.

- Cosmetic Dentistry
- General Dentistry
- Night Guards
- Teeth Whitening
- Crowns
- Bridges
- Invisalign®

Excellence in Dentistry

RANCHO NIGUEL DENTAL GROUP

30140 Town Center Drive, Laguna Niguel, CA 92677 • 949/ 249-4180 • Fax: 949/249-4185

Acknowledgement of Receipt of

HIPPA Notice of Privacy Practices

This form acknowledges your receipt of the HIPPA Notice of Privacy Practices, or our good faith effort to obtain that acknowledgement. (please print)

PATIENT'S LAST NAME _____

FIRST NAME _____

Rancho Niguel Dental
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2016, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts. **Required by Law.** We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disibility
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

For Office Use Only Below This Line

Please specify the reason the patient chose not to sign the acknowledgment of receipt of the HIPPA Notice of Privacy Practices.

☐ Patient / Parent of Legal Representative received the HIPPA Notice of Privacy Practices but refused to sign the acknowledgment of Receipt.

☐ Patient / Parent of Legal Representative unavailable to acknowledge receipt of the HIPPA Notice of Privacy Practices.

Staff Signature:_____ Date: _____

If you would like a copy of this notice for your records, please inform our staff.

X _____ Date: _____ _____ Date: _____

Patient / Parent's Signature: Patient Representative's Signature:

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights Access.

You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official.

If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Debbie Canu: *Debbie Canu*

Telephone: (949) 600-7046 Fax: (949) 600-

Address: 27 Spectrum Pointe Drive, Suite 308, Lake Forest, CA 92630-9899

E-mail: dcanu@socaldentalpartners.com

RANCHO NIGUEL DENTAL GROUP

DENTIST

PATIENT

1 WORK TO BE DONE

I understand that I am having the following work done: ○ Fillings_____ ○ Crowns_____ ○ Extractions_____ ○ Dentures_____ ○ Impacted Teeth Removed_____ ○ Root Canals_____ ○ Periodontal Treatment_____ ○ Other_____

2 DRUGS, MEDICATIONS, AND X-RAYS

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. X-Rays are taken by qualified personnel. Exposure to X-Ray radiation (minimal). X-Ray pictures remain the property of this office. Full mouth series of X-Rays may be necessary to aid in diagnosing future dental treatment.

3 CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions that were not discovered during examination but were found while working on the teeth. For example, root canal therapy may be discovered to be needed during routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

4 CROWNS, BRIDGES, AND OTHER DENTAL CASTINGS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including the shape, fit, size, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation.

5 FILLINGS

I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling.

6 ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth which does not necessarily effect the success of the treatment. I understand that endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost despite all effort to save it

7 REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth_____ _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue, or fractured jaw. I understand removal of teeth can result in paraesthesia that can last permanently or for an indefinite period of time, and that paraesthesia numbness is a possible risk of injection/extraction. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

8 PERIODONTAL LOSS (TISSUE AND BONE)

I understand that I have a serious condition causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements, and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

9 DENTURES

I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate dentures (placement of denture immediately after extractions) may be painful. Immediate dentures may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.

10 DENTAL MATERIALS FACT SHEET ACKNOWLEDGMENT

Rancho Niguel Dental Group made the Dental Materials Fact Sheet available to me to read in the office and/or take home. I acknowledge that this was made readily available for me and I have chosen to or not to read this material.

I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand that no other Dentist is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

I understand that this practice provides space, equipment, support personnel and administrative services to allow each dentist to focus on patient care. The individual dentists practicing at this practice are not agents or employees of this practice. Each of them exercises independent professional judgement in the nature and manner of dental care and treatment provided. I ACKNOWLEDGE THAT I AM AWARE THAT ALL OF THE DENTISTS ARE NOT EMPLOYEE AGENTS OF THIS DENTAL MANAGEMENT COMPANY.

X_____ _____ DATE_____
SIGNATURE OF PATIENT

X_____ DATE _____
PLEASE PRINT NAME, IF A MINOR, PLEASE PRINT THE MINORS NAME

If the patient is under the age of 18 years old, please have a parent or legal guardian sign this form

X_____ WITNESS_____
SIGNATURE OF DOCTOR

X_____ DATE_____
SIGNATURE ☐ *PARENT / GUARDIAN* ☐ *SPOUSE*

❹ *CROWNS, BRIDGES, AND OTHER DENTAL CASTINGS*

DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
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DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR

❺ *FILLINGS*

TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR

❻ *ENDODONTIC TREATMENT (ROOT CANAL)*

TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR

❼ *REMOVAL OF TEETH*

TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR
TOOTH NUMBER	PAT INIT	MO.	DAY	YR	TOOTH NUMBER	PAT INIT	MO.	DAY	YR

❽ *OTHER PROCEDURES*

DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR
DESCRIBE	PAT INIT	MO.	DAY	YR	DESCRIBE	PAT INIT	MO.	DAY	YR

ADJUNCTIVE ORAL CANCER SCREENING ACCEPTANCE FORM

Complete each time the examination is performed and place in the patient's file.

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk for oral cancer. Though tobacco use is a major predisposing factor, **25% of oral cancer victims have no lifestyle factors.**

Oral Cancer Risk Profile

Increased Risk

-Patients age 40 and older (95% of all cases)
-18-39 years of age combined with any of the following:
-Tobacco use
-chronic alcohol consumption
-Oral HPV infection

Highest Risk

-Patients age 65 and older with lifestyle risk factors
-Patients with history of oral cancer
-25% of oral cancers occur in people who don't smoke and have no other risk factors.

We find using the ViziLIte Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your ife. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for the enhanced examination is $65.00.

Yes, I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

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

Print name: _____

Signature: _____ Date: _____