Spectrum Dentistry
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Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ Best time to call:_____ (Cell): _____

E-mail: _____@_____._____ Driver's Lic.#: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you currently taking any medication(s)? ☐ Yes ☐ No
  If yes, please list:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Mailer ☐ Clipper ☐ Internet ☐ Website ☐ Other_____

Name of person or office referring you to our practice:_____

Please Continue to Page

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Employers Phone #: _____ Ext:_____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Service

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I consent to have the complete examination with the necessary dental x-rays, complete oral evaluation and cleaning in order to provide a realistic and comprehensive treatment plan.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have received a copy of the Dental Materials Fact Sheet/Notice of Privacy Practices.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian_____ Date: _____ Relationship to Patient: _____

Financial Responsibility Form

Name _____

I understand that as a subscriber/member of _____ Dental Plan/Insurance some services will require a co-payment from me. The amount of that co-payment will vary according to the insurance plan and the procedure that is performed. In addition if a plan has an annual deductible I understand that it must be satisfied before my plan benefits begin. (Initials_____)

I understand that dental services not covered by my plan may be diagnosed in certain cases. Non-member fees will be charged for such services. (Initials_____)

I understand that all co-payments, deductibles and non-member charges are due when services are rendered. (Initials_____)

I understand that there will be a $50.00 charge for any missed appointments which are not cancelled at least 48 hours in advance. (Initials_____)

Hygiene appointments: If you are unable to keep your appointment, please call our office at least 72 hours prior to your appointment to reschedule an appointment time. This courtesy allows the hygienist to give your appointment to another patient. There will be a $50 charge for any missed appointments which are not cancelled at least 72 hours in advance. Your cooperation will allow us to better serve you. (Initials_____)

I understand that I may obtain a copy of my radiographs for a fee of $50.00. (Initials_____)

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Spectrum Dentistry Date

Spectrum DENTISTRY™

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 the 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.** Oral cancer risk by patient profile is as follows:

Increased risk: *patients age 18 – 39 (because of the association with HPV)*
High risk: *patients age 40 and older; tobacco users (any age, any type within 10 years)*
Highest risk: *patient 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 allows us to detect oral cancer lesions 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 precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus will be offered to you annually.

The enhanced examination is recognized by the American Dental Association code revision committee as CDT-% procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is **$65.00.** Our office will gladly assist you by providing the proper insurance forms for possible reimbursement.

I have received and read a copy of the Oral Cancer information sheet:

_____	_____	_____
Print Name	Signature	Date