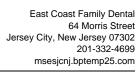




New Patient Form											
	fidential.		mation to the best of your any questions, plea				Date	e: / /	F	Patient #:	
Patien	t Info	rmatio	n								
Title:	First Na	st Name: Middle Name:			Last Name:				I prefer to be called:		
Sex:	Age:	e: Date of Birth (mm/dd/yyyy): Marital Status:			tus:	Soc	Social Security #: Driver's Licence State & #:				
Home F	•	Work Phone:	Phone:	E	E-mai	il Address:					
Home A	\ddress:					City	y:			State:	ZIP Code:
Employment: Employer's Name: Employer's Pho					yer's Phone: -	0	Occupation:				
Employer's Address:						City	City: State: ZIP Code.				ZIP Code:
Student	t Status:	Sc	hool Name (if a full-t	ime student):	:	Grade:				·	
			to contact you:					Send appointm Text Mess		ders via: Email	Mail
Frie Ad i	end or F in Mail arch En	Relativ	ou heard about us (che (name): aw our Office Google, etc.)		Ne e Company	wspapo / C		d Radio Website	Ad	TV Ad	
Was o	ur web	site a	factor in your ded	cision to vis	sit our prac	tice?	Ye	s No			
Name o	of Spous	e (or Pa	arent, if a minor): Sp		•				e: Spouse	e/Parent Ce 	ell Phone:
Other fa	amily me	embers	treated by us:		Add	ditional C	Comr	nents:			



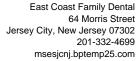


Emer	gency (	Contact	t										
This sh	ould be	the neare	est relat	ive who does no	t live	witi	h the patient.						
Title:	First Na	ame:		Last Name:				Relationship to Patient:					
Home Phone: Work Pho		Phone:	Cell Phone:			E-mail Address:							
Emerge	ency_Co	ntact Add	dress:					С	ity:			State:	ZIP Code:
Perso	n Resp	onsible	for A	ccount									
Title:	First Na	ame:		Middle Name:			Last Name:				Relationshi	p to Pati	ent:
Date of	Birth (m	nm/dd/yyy /	y): So	cial Security #: 		Driv	ver's Licence Sta	ate	& #:	Holder of D	ental Insura	nce for F	atient:
Home F	Phone:	-	Work I	Phone:	Ce	ell P	hone:		E-mail A	ddress:			
Billing A	Address:							С	ity:			State:	ZIP Code:
Employ	ment:	Employe	er's Nar	ne:	Em	nploy	yer's Phone: 		Occupatio	on:			
Employ	er's Add	lress:						С	ity:			State:	ZIP Code:



East Coast Family Dental 64 Morris Street Jersey City, New Jersey 07302 201-332-4699 msesjcnj.bptemp25.com

<b>Insurance Informa</b>	tion									
<b>Primary Insurance</b>										
Insurance Holder's Name:		Date of B	irth (mm/dd/yyyy): /	Rela	tionship to Patient:	Employer:				
Member ID:	Group I	ID:		Insurance Compar	ny Na	me:	Ins	surance C -	company -	Phone:
Insured's SSN:		Insura	ance Comp	pany's Address:		City:			State:	ZIP Code:
Secondary Insurance	e									
Insurance Holder's Nam	ne:		Date of B	irth (mm/dd/yyyy): /	Rela	tionship to Patient:	Emp	loyer:		
Member ID:	Group I	ID:		Insurance Compar	ny Na	me:	Ins	surance C -	Company Phone:	
Insured's SSN:	I	Insura	ance Comp	pany's Address:		City:			State:	ZIP Code:
Authorization										
insurance submission understand that I are helping me to obtain Dental. I permit a condition Dental, its employed including cell number insurance, or payments.	n responding paymones, and ess, and ers (by ent.	onsible ent fro his au l/or ot phon	e for my om my ir uthorizati her ager e call or	bill. I authorize Insurance compa ion to be used in its express prior text message) a	East inies i plad con ind e	Coast Family Del c. I authorize paym ce of the original. sent to contact me	ntal to nent to I give e at a	act as concerning act as conce	my age coast F coast Fa none nu e of tre	amily amily umbers, eatment,
Signature (Type your na	ame to s	ign ele	ectronically, or print and sign):				Date (mm/dd/yyyy): / /			уу):
<b>Consent for Treatm</b>	nent									
Patient Name:										
I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.  Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.  I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.  I have read, understood, and agree to the above treatment policy.										
Signature (Type your na	ame to s	ign ele	ctronically	, or print and sign):				Date (mm/dd/yyyy): / /		





# **Payment**

Does the person responsible for the account already have an account with this office? Yes No

# **Payment Method**

method of payment		ne or service uniess aiternative	arrangements na	ive peen made in advance. Please choose a
Payment in Full				
Cash				
Check				
Credit Card	Type:	Credit Card Number:	Expiration:	Card Verification Code:  VISA/MC/Discover: 3-digit code printed on back  AmEx: 4-digit code printed on front
	Your crec	lit card information is kept	on file for outs	standing account balances.
<b>Payment Plans</b>				
Start treatment imm	ediately and	pay over time with low monthly	/ payments.	
CareCredit	• Pa	• • •	minimum mon	n NO interest. thly payment each month when due, romotional 6- or 12-month term, no

interest will be charged on your purchase.

## **Low-Interest Payment Plans**

- Enjoy low monthly payments with the 24, 36, 48, or 60 month extended plans.
- The 14.9% APR is lower than average credit cards and makes convenient, fixed, and low minimum monthly payments possible. This option is available for treatment fees of \$1000.00 or more. (\$5000.00 or more for the 60 month plan.)

If you choose this option, you can fill out a CareCredit application at our office.

Would you like to discuss our office's financial policy? Yes No



East Coast Family Dental 64 Morris Street Jersey City, New Jersey 07302 201-332-4699 msesjcnj.bptemp25.com

## **Payment Policies**

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

#### For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

#### **Returned Checks**

Personal checks that are returned due to "insufficient funds" are subject to a \$25.00 service fee.

#### **Service Charge**

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$2.50 for a minimum balance of \$25.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. Please be advised that there is a \$50.00 fee charged for missed or broken appointments without 24 hours notice. To avoid this charge, kindly give us a minimum of 24 hours notice for any appointment cancellation. Feel free to contact us at any time with questions you may have.

#### X-Ray/Records Release

There is a fee of \$25.00 for any release of X-rays and/or records.

#### **Minors**

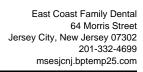
Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

#### **Authorization**

Patient Name:

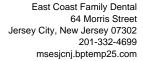
I hereby authorize payment directly to East Coast Family Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to East Coast Family Dental to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
	/ /





Dental History								
<b>Previous Dentist</b>								
Dentist Name:	Dental Practice I	Name:		Phone:	-			
Address:		City:	,		State: 2	ZIP Code:		
What did you like about your last dentist?	V	What caused yo	ou to leave your las	st dentist?	,			
Last Dental Visit								
Last Dental Visit (m/y): What were you treated	I for?				atment co	omplete? No		
What was done at your last dental visit?	L	ast X-Rays: /	Last Full-Mout	h X-Rays:	Last Cle	eaning:		
<b>Dental Hygiene</b>								
How often do you visit a dentist? Do you bru	sh your teeth? If y	es, how often?	Do you floss? I	f yes, how	often?			
Please list other dental hygiene aids (Interplak, to	oothpicks, etc.) th	at you use: A	are you interested	in regular h	nygiene c	leanings?		
Today's Visit								
Do you have any dental problems, pain, or disco	mfort at this time?	If yes, please	describe:					
What is the main reason for your visit today?  Tooth Pain Check-up Cleanir Sedation Dentistry Restorative De	•	ng Cosn ner:	netic Dentistry					
What would you like to learn more about? Whitening Cosmetic Dentistry Dentures Other:	Sedation Der	ntistry Im	nplants Brid	dges	Venee	'S		
<b>Dental Concerns</b>								
Check all that apply.								
Teeth	ain a fillin a	Mississats	-41-	C = 10 = 14	: 4			
Broken or chipped Loose/miss		Missing te			ive to s			
Crooked Loose teet		Mouth sor			•	s/mouth		
Decay Tooth pain		Sensitive t				eatment		
Difficulty chewing Food trap		Sensitive t		Bad ta	ste in n	nouth		
Discolored Grinding o	r clenching	Sensitive	when biting					
Gums								
Bad breath Abscessed	d	Sore		Reced	•			
Red (discolored) Bleeding		Swollen		Period	ontal tr	eatment		





Facial/Jaw Pain			
Frequent headaches	Pain in temples	Jaw injury	Pain around ear
Avoid certain foods	Jaw locks open/closed	Head injury	
Popping/clicking	Pain in jaw	Neck injury	
Other Concerns			
Smoking/dipping	Orthodontic trea	atment	Snoring
Biting cheeks or lip	Burning tongue		Teeth straightening
Popping/clicking	Tooth replacem	ent	Retainer
TMJ	Fractured tooth	syndrome	Dry mouth
Tooth-colored fillings	CPAP		Wisdom teeth extraction
Wisdom teeth	Implants - Tootl	า #:	Cosmetics
Nail-biting	Jaw locks open	/closed	Smile makeover
Sleep apnea	Stain		Dental phobias
Limited orthodontics	Chew on one si	de	
Does food tend to get caught be	etween vour teeth? If ves. where?		

Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth? If yes, what?

# Have you ever had:

Check all that apply.

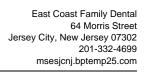
Your bite adjusted Orthodontic treatment Periodontal treatment

Your teeth ground A bite plate or mouth guard Oral surgery

Any canker sores or cold sores on your lips, tongue, gums, or body

A serious injury to the mouth or head? If yes, please describe including cause:

Ratings	
1 2 3 4 5	On a scale of 1-5 (1 bad, 5 good), please rate how you feel your overall dental health is.
1 2 3 4 5	On a scale of 1-5 (1 bad, 5 faithful), over the last ten years, rate how faithfully you have had your teeth cleaned.
1 2 3 4 5	on a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your level of sensitivity to dental procedures?
1 2 3 4 5	appointments?
1 2 3 4 5	On a scale of 1-5 (1 unhappy, 5 very happy), rate how you feel about the look of your smile.
1 2 3 4 5	On a scale of 1-5 (1 poor, 5 great), how do you rate your quality of sleep?
1 2 3 4 5	On a scale of 1-5 (1 being low, 5 being high), if you snore, how would you rate the severity of your snoring?





Miscellaneous							
Has fear ever been an issue for you in a	dental office? Yes	s No					
Has time ever been a factor in getting your dental work done? Yes No							
Has the cost of dental treatment been a	concern for you?	Yes No					
If yes, how can we help?							
Tell us about your good dental experiences/visits	: Tell us a	about your bad c	dental experiences/fo	ears:			
What do you like most about your teeth/smile?							
Is there anything you don't like about your teeth/s	smile?						
Is there anything you'd like to change about your	teeth/smile?						
What are your long-term dental goals? How would	d you like your teeth to f	eel and look?					
What are your short-term dental goals?							
Do you have any upcoming event or circumstance yes, what and when?	es (such as weddings, n	najor surgeries,	etc.) we should/need	to know about? If			
Is there anything else you feel we should know?	Medical Histor	<b>rv</b>					
How is your general health? Good	Fair Poor	- J					
Are you currently under medical treatment? If yes							
Do you require antibiotic pre-medication for your	dental work? If yes, wha	t for?					
Physician's Name:	Phone:	Last Visit:					
Address:		City:		State: ZIP Code:			
Do we have permission to contact your d	octor regarding you	care? Yes	s No				

Renal dialysis

Spina bifida



**Dizziness** 

**Epilepsy** 

# Have you ever had: Check all that apply. Arthritis

Recent weight loss Seizures Abnormal bleeding Arthritis Arteriosclerosis Fainting Ulcers/colitis Rheumatism Birth defects Hearing disorders Scarlet fever Difficulty breathing Cancer High or low blood Hospitalized for any Sexually transmitted disease **Emotional problems** sugar reason Hypotension (low Sickle cell anemia Emphysema Head or face injury blood pressure) Glaucoma Sinus trouble Heart murmur/trouble Nervous disorder Thyroid disease Tattoos/body piercing History of substance Rheumatic fever abuse/drug addiction TMD/TMJ (jaw pain) **Angina** Heart attack/stroke Kidney problems Artificial hip/joints X-ray or cobalt treatment Heart surgery Numbness of arms or Gout Pacemaker hands Yellow jaundice Chest pain Chronic fatigue Swollen, still painful Artificial valves Circulatory problems joints syndrome Congenital heart Cold sores **Allergies** defect Cough-persistent or Congenital heart bloody **Asthma** Mitral valve prolapse lesion Latex sensitivity **Blood disease** Artificial bones/joints Cortisone medicine Smoker Diabetes Shingles Convulsions Swelling of feet/ankles Endocrine problems **HIV/AIDS** Herpes Swollen neck glands Intestinal disorders **Blood transfusions** Leukemia **Tonsillitis** Hepatitis A. B. or C Fever blisters Excessive thirst Tumor or growth on Hypertension (high Sinus problems Hay fever head/neck blood pressure) Severe/frequent Heart disease Easily winded Liver problems headaches Hives/skin rash Pneumonia Anaphylaxis Cancer/chemotherapy Hypoglycemia Shortness of breath Radiation treatments Alzheimer's disease Irregular heartbeat Frequent diarrhea Psychiatric problems Anemia Lung disease Bruise easily **Tuberculosis** Genital herpes Osteoporosis

# Have you ever had an adverse reaction or allergies to any medication or substance?

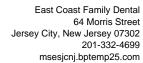
Venereal disease

Hemophilia

Thave you ever had an adverse reaction of anergies to any medication of substance.									
Check all that apply.									
Acrylic	Dental anesthetics	Nitrous oxide	Tetracycline						
Aspirin	Erythromycin	Novocaine	Valium						
Barbiturates (sleeping	Iodine	Penicillin/antibiotics	Xylocaine						
pills)	Latex rubber	Sedatives							
Codeine	Metals	Sulfa drugs							

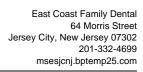
Pain in jaw joints

Parathyroid disease





Are you being/have you ever been treated for cancer of any kind? If yes, please explain: Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). Nο Do you take or have you taken Phen-Fen or Redux? No Do you smoke or chew tobacco? Nο Do you use alcohol, cocaine, or other drugs? Yes No Do you wear contact lenses? Yes No Are you on a special diet? No Yes Have you lost or gained more than 10 pounds in the past year? Yes No Do you use more than two pillows to sleep? Have you ever had any excessive bleeding requiring special treatment? Yes No When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? No Have you been treated in a hospital in the last five years? Yes No If female, please mark if you are: Pregnant - If so, please enter your due date or week #: Nursing Trying to get pregnant On birth control Please list all current prescriptions: Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment: Do you wish to talk to the dentist privately about any problems/concerns? Yes Nο All of the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you. Signature (Type your name to sign electronically, or print and sign): Date (mm/dd/yyyy): For office use: Reviewed by: Title: Date:





Our Office
What do you already know about our office and what are your expectations?
What would it take for you to trust us to be your dentist?
We can look at your mouth from 3 different perspectives. This will help us determine how to best treat you and your specific dental needs. What combination of these would you like us to use for your situation?
As a general dentist As a cosmetic dentist As a functional (bite, TMJ) dentist
At what point do you want us to initiate treatment for you?
When something isn't ideal When something worsens When my tooth hurts or breaks



# **HIPAA Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting
  quality assessment and improvement activities, auditing functions, cost-management analysis, and
  customer service. An example would be an internal quality assessment review. We may also create
  and distribute de-identified health information by removing all references to individually identifiable
  information.
- To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders



of courts or administrative agencies

- Disclosures for law enforcement purposes, such as to provide information about someone who is or
  is suspected to be a victim of a crime; to provide information about a crime at our office; or to report
  a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

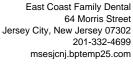
- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 3, 2019, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

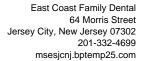
If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S.





Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights 200 Independence Avenue, S.W. Washington D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-6775





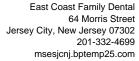
#### **HIPAA Patient Consent Form**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize East Coast Family Dental to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

Additionally, I authorize you to share all my protected health information with the following individual(s):

Name:		Relationship:	Phor	ne: -	_	
Name:		Relationship:	Phor	ne:		-
			-	-	-	
Name:		Relationship:	Phor	ne: -	-	
		nt to review and secure a			•	
personal health information the terms of this notice from the terms of this notice from the terms of the term	on, and my rights under hom time to time and that le right to request restriction atment, payment and head estrictions. However, if you nat I may revoke this contributed to the date I revoke the	otion of the uses and disclostion of the uses and disclostion of the most cursions on how my protected lathcare operations, but the use do agree, you are then be sent, in writing, at any time this consent will not be affection.	ou reserverent copy health informate you are bound to dealth.	e the right of this ormation not recomply er, any	ght to change notice. I n is used and puired to agree with this use or	
Signature (Type your name to	sign electronically, or print and	d sign):	]	Date (mn	n/dd/yyyy): /	
If signing on behalf of someon	e, explain your relationship to	the patient:				
For Office Use Only Patient refused or was unable	to sign. Good faith effort was	made to obtain acknowledgeme	ent of recei	ot.		
The following circumstances p			,			
Describe your good faith effort	to obtain the individual's signa	ature on this form:				
Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date	): 	/	
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# **Oral Cancer Screening Form**

Our dental practice continually looks for advances to ensure that we are providing the optimum level of oral healthcare 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 of increasing incidence and mortality rates of oral cancer. 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 age 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)
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HIGHEST RISK: Patients age 40 and older with lifestyle risk factors (tobacco previous history of oral cancer	and/or alcohol use);
Please select one:	
YES - I would like to have the oral cancer exam.	
NO - I would prefer not to have the oral cancer exam at this time.	
Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
	/ /