



Patient Information

Patient Name: _____

Address: _____ City _____ Zip _____

Home# _____ Work# _____ Cell# _____

Occupation: _____ Employer: _____

Height _____ Weight _____ Date of Birth _____ Sex: M F

SS# _____ Referred by: _____

Emergency Contact: _____ Phone# _____

Responsible Party

Name: _____ Relationship: _____

Address: _____

Home# _____ Work# _____

Insurance Policy

Name of Insured: _____ Date of Birth _____

SS# _____ Employer: _____

Insurance Company: _____

Insurance Address: _____

Insurance Toll Free Phone# _____

Policy# _____ Group# _____

Dental Questionnaire

1. When was the last time you had your teeth cleaned? _____
2. When was the last time you had dental work? _____
3. Do you have well or county water? _____
4. What over the counter oral rinses are you using? _____
5. Do you take fluoride supplements? Yes No
6. Have you ever had periodontal (gum) treatment? Yes No
7. Have you ever had orthodontic treatment? Yes No
8. Do you floss regularly? Yes No
9. Do your gums bleed when you brush or floss? Yes No
10. Have you ever been concerned about bad breath? Yes No
11. Do you consistently get a bad taste in your mouth? Yes No
12. May we take any needed dental xrays? Yes No
13. Circle type of toothbrush you are using: Hard Medium Soft Electric
14. What are your dental goals? _____

Patient Medical History

- | | | |
|--|-----|----|
| 1. Have you ever been seriously ill?
If yes, please explain. _____ | Yes | No |
| 2. Have there been any changes in your general health lately?
If yes, please explain. _____ | Yes | No |
| 3. Is a medical doctor currently treating you?
If yes, who & please explain. _____ | Yes | No |
| 4. Please list any medications you take. _____ | | |
| 5. Have you ever had major operation or been hospitalized?
If yes, please explain. _____ | Yes | No |
| 6. Have you had a physical exam within the last year? | Yes | No |
| 7. Have you ever had to take antibiotics (PRE-MED) before having dental work? | Yes | No |
| 8. Do you have chest pains upon exertion? | Yes | No |
| 9. Have you ever had xrays for a tumor, growth, or other condition? | Yes | No |
| 10. Please circle any from the list below that you are allergic to or have had reaction to:
penicillin erythromycin codeine
aspirin sulfa drugs local anesthetics
iodine barbituratates latex
other: _____ | | |
| 11. Are you currently using any recreational drugs? | Yes | No |
| 12. Had you ever had a blood transfusion? | Yes | No |
| 13. Do you have shunts for dialysis or any other condition? | Yes | No |
| 14. Do you bleed for a long time when you cut yourself? | Yes | No |
| 15. Do you have frequent or severe headaches? | Yes | No |
| 16. Do you have sinus trouble? | Yes | No |
| 17. Do you have painful or swollen joints? | Yes | No |
| 18. Do you have frequent cold sores or mouth ulcers? | Yes | No |
| 19. Do you have complaints about your ears/hearing? | Yes | No |
| 20. Do you have frequent colds? | Yes | No |
| 21. Do you wear contact lenses? | Yes | No |
| 22. Do you use tobacco? | Yes | No |
| 23. Are you nervous? | Yes | No |
| 24. Have you ever had or now have any of the following diseases or problems: | | |
| Mitral Valve Prolapse Yes No Kidney Disease Yes No | | |
| High Blood Pressure Yes No Arthritis Yes No | | |
| Low Blood Pressure Yes No Epilepsy Yes No | | |
| Heart Attack Yes No Abnormal Bleeding Yes No | | |
| Heart Murmur Yes No Jaundice Yes No | | |
| Diabetes Yes No Rheumatic Fever Yes No | | |
| Asthma Yes No Tuberculosis Yes No | | |
| Hepatitis Yes No Venereal Disease Yes No | | |
| Seizures Yes No Hives/Skin Rash Yes No | | |
| Stroke Yes No Artificial Bones Yes No | | |
| AIDS (HIV) Yes No Difficulty Breathing Yes No | | |
| Anemia Yes No Pace Maker Yes No | | |

For Women Only (questions 1-3)

- | | | |
|---|-----|----|
| 1. Are you currently pregnant or suspect you may be pregnant?
If yes, how far along are you. _____ | Yes | No |
| 2. Are you currently nursing? | Yes | No |
| 3. Are you taking birth control pills or hormonal replacement? | Yes | No |

All information provided here is 100% confidential and any attempt to conceal pre-existing conditions or other relevant information could result in serious patient drug interactions or death. Please carefully review the above medical history you have provided before signing.

I have read and understand the above questions. I have answered all these questions truthfully to the best of my ability and knowledge.
Signature _____ Date _____



Welcome to our Practice

Thank you for choosing our office for your dental care. We are dedicated to providing you and your family with the highest quality of care, using state of the art treatment in a comfortable and professional environment. Please familiarize yourself with the policies of this office. This form must be read and signed before treatment is rendered. Please ask questions if you do not understand any of these policies.

Financial Agreement

- I understand that payment for services is completely my responsibility.
- I understand that my insurance is an agreement between the insurance company and me and not between Dr. Venet and the insurance company. (We file insurance as a courtesy.)
- I must provide the correct dental insurance information for this office to accept insurance as a payment.
- If insurance cannot be verified or if I do not have insurance, I will pay in full with cash, check or credit card at time of service.
- I also understand that I am responsible for any balance over 30 days.
- I understand that if for any reason my account is turned over to a collection agency, I will be responsible for any and all fees to collect my balance.

Appointments

In order to give the most efficient care; we work within an appointment system. Our office hours are Monday through Thursday, 8am to 5pm. (Closed for lunch 1-2pm.) We make every effort to honor all time commitments and expect patients extend us the same courtesy. We are available when emergencies arise, and will do our best to give prompt consideration as needed. We aim to give you all the time and attention you need while in our office. If you are more than 15 minutes late for your appointment we may need to reschedule you to allow enough time for your treatment.

Cancellation Policy

I understand that if I am unable to keep my scheduled appointment for any reason, I will notify the office at least 24 hours in advance of my scheduled appointment time. I understand that I should call the office and confirm my appointment within 24 hours. Please note schedule changes will be accepted during regular office hours. I am aware that I may be charged a fee if I do not provide 24 hours notice of cancellation or do not show up for the appointment. The fee will vary depending on the amount of time scheduled and will not be less than \$50.00. If you fail to show up for two appointments, we may not be able to schedule you any more appointments.

Parents

You may accompany children in the operatories by invitation only. However, we do require you remain in the building with minor children (under 18 years of age) for the entire appointment. We provide children with the same care that our adult patients receive and prefer to care for them as individuals.

I CERTIFY THAT I HAVE READ, UNDERSTAND AND AGREE TO THE FINANCIAL AND OFFICE POLICY PROVISIONS STATED ABOVE.

Patient Name (please print): _____
Patient/Guardian Signature: _____ **Date** _____



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of
this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An Emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)



ORAL SCREENING CONSENT FORM

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 cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors **but more that 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk: *patients ages 18-39
-sexually active patients (HPV 16/18)*

High risk: *patients age 40 and older; tobacco users (any age, any type within 10years)*

Highest risk: *patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer*

We have recently incorporated ViziLite® Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possible save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is \$50.

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: _____