

Welcome to

PREMIER DENTAL Arts

Your name: _____

Date: _____

In order to help us serve you better please mark with X one of the following:

How did you hear about our office?

___ **Another patient (their name _____)**

___ **Internet Search**

___ **Yellow pages**

___ **US 1 Newspaper**

___ **Hamilton Post**

___ **Lawrence Gazette**

___ **Robbinsville Advance**

___ **Valpak**

___ **Clipper Magazine**

___ **Movie News**

___ **Your Dental Insurance Company**

___ **Sign on the building**

___ **Other:** _____

Medical and Dental History Form

Patient name: _____ D.O.B. _____

What was the reason for today's visit? _____

When was your last dental visit? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like most about your last dentist? _____

Medical History and Information Please check if you have any of the following:

Conditions

- Abnormal Bleeding
- Alcohol Abuse
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Heart Valve
- Asthma
- Blood Transfusion
- Cancer
- Chest Pain
- Chemotherapy
- Colitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Dry Mouth
- Drug Abuse
- Emphysema
- Epilepsy
- Facial Surgery
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- Glaucoma
- HIV/AIDS
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- Jaundice
- Joint Replacement
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever
- Seizures
- Sexually Transmitted Disease
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Transplants
- Thyroid Problems
- Tuberculosis
- Ulcers

Allergies

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline

Other _____

Y N

Do you Smoke
or use Tobacco?

If Female

Y N

Are you taking Birth
Control Pills?

Are you pregnant?
If yes, # of weeks

Are you Nursing?

Please list any condition not mentioned above: _____

Please list any medications
you are currently taking: _____

I certify to the above statements regarding my medical condition are true and correct and hereby give my consent for treatment. Payment for all treatment and services rendered are my responsibility.

PATIENTS SIGNATURE

DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE

DATE

Premier Dental Arts Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an one's physical and psychological well-being. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

We will file dental insurance claims on your behalf as a courtesy. We will also work to obtain estimates for cost of treatment whenever possible. The primary party is responsible for final payment of any balances after insurance benefits have been determined according to their contract.

Payments are expected at the time services are rendered. We accept cash, checks (under \$500.00), debit cards, Visa/Mastercard.

Optional Payment Terms:

1. **Major Service - Two Payment Option:** We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half at the completion date.
2. **Term Loan:** By arrangement with Care Credit, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

Cancelled appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hours notice to avoid a \$50.00/hour cancellation fee (emergencies are an exception).

Returned checks and delinquencies: I understand that returned checks will impose a \$35 returned check fee. I also understand that Premier Dental Arts may report any unpaid balances to a credit reporting agency and that I may be responsible for any fees associated with the collection of my unpaid balance.

Name _____ Date _____

Signature _____

Information about Vizilite Oral Cancer Screening

In our continuing efforts to provide the most advanced technology and highest standard of care available to our patients, this practice is proud to announce the inclusion of the ViziLite® Plus exams as an integral part of our annual comprehensive oral screening program.

One person dies every hour from oral cancer in the United States – and the mortality has remained unchanged for more than 40 years. 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 other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **27% of oral cancer victims have no lifestyle risk factors**. According to the American Cancer Society, more women in the United States will be diagnosed with oral cancer this year (12,000 cases) than will be diagnosed with cervical cancer (< 10,000 cases), and there are as many cases of oral cancer caused by the human papilloma virus (HPV 16/18), a sexually transmitted disease, as there are HPV-related cases of cervical cancer.

Clinical studies have determined that using ViziLite Plus after the standard oral cancer examination improves the dental professional's ability to identify and evaluate suspicious areas at their earliest stages. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. Proven screening technologies such as mammogram, Pap smear, PSA and colonoscopy offer the same type of early detection of cancer. ViziLite Plus is an easy and painless examination that gives this practice the best chance to find any oral abnormalities you may have at the earliest possible stage.

Oral cancer risk by patient profile is listed below:

Increased Risk: Patients age 18 – 39
- sexually active patients (HPV 16/18)

High Risk: Patients age 40 and older; tobacco users younger than age 40

Highest Risk: Patients age 40 and older and lifestyle risk factors (tobacco use); patients with a history of oral cancer;

Dental insurance might not cover this advanced oral cancer screening as an addition to the standard visual examination. This office will provide you with a medical insurance form for you to use to file this procedure with your medical insurance.

This practice prescribes the ViziLite Plus exam for all patients at increased risk, high risk and highest risk for oral cancer (adult patients age 18 and older and tobacco users of any age). We will be performing the ViziLite Plus exam annually following the standard oral cancer examination of the oral cavity for a fee of **\$71**.

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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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. 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.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Paula Micale
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E-Mail: drwu@premierdentalarts.com
Address: 3800 Quakerbridge Rd, Suite 1
Hamilton, NJ 08619