IMAGECARE
Dental Health History UPDATE and QUESTIONNAIRE

It is important that we know your medical and dental history. This information has a direct bearing on your Dental Health is kept strictly confidential in accordance with HIPAA guidelines. Thank you.

Patient Name: ___________________________________ Address____

Phone #_________________________________DOB: _____________________________Email:_____________________________

Y N Have you experienced any health problems in the past year? Explain
____

Y N Are you under a Physician's care now? If **YES** please explain
____

Y N Do you Pre-Medicate? (Ex: Heart murmur, Mitral valve prolapse, joint replacement, heart condition)

Y N Are you pregnant? (If "yes". OBGYN Name___________________________& Phone #______________________)

Y N Do you smoke?

Y N If we could offer you a simple, effective way of whitening your teeth, would you be interested?
Y N Are you concerned about your smile or dental health in any way? Explain____________________________________

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment.
_____Fear of pain ______Lack of concern ______Cost of treatment ______Missing work time

List all medications you're currently taking ____

Circle and or add medications to which you are allergic or have ever reacted adversely.

Aspirin Codeine Local Anesthetic Nitrous Oxide Erythromycin
Penicillin Latex Sulfa
(Other Specify)____

Check any of the following that you have had or presently have:

__ Heart disease or attack
__ Angina Pectoris
__ High Blood Pressure
__ Heart Murmur
__ Rheumatic Fever
__ Congenital heart failure
__ Mitral Valve Prolapse (MVP)
__ Artificial heart valve
__ Heart Pacemaker
__ Heart surgery
__ Artificial joints (hip, knee)
__ Anemia
__ Stroke
__ Kidney trouble
__ Ulcers

__ AIDS/ARC/HIV Positive
__ Hepatitis A (infectious)
__ Hepatitis B (serum)
__ Liver disease
__ Blood transfusion
__ Drug Addiction
__ Hemophilia
__ Fever blisters
__ Epilepsy or seizures
__ Nervousness
__ Psychiatric treatment
__ Glaucoma (Type ____________)
__ Osteoporosis
__ Venereal disease
__ Bruise easily

__ Chemotherapy (If "yes", provide dates________)
__ Tuberculosis (TB)
__ Asthma
__ Hay Fever
__ Sinus trouble
__ Allergies or hives
__ Diabetes
__ Thyroid disease
__ Radiation treatment
__ Arthritis
__ Cortisone medicine
__ Pain in jaw joints
__ Blood thinners (ie: Coumadin)
__ Cosmetic surgery
__ Alcoholism

Y N Have you or are you taking any of the following medications (Bis-Phosonates) Aredia Zometa Fosamax Actonel or Boniva ?
(If "Yes" please specify date and reason for taking From____________to_____________, for_________________________)

Y N Have you or are you taking any of the following medications (SSRI's) Lexapro Prozac Paxil Zoloft Luvox Effexor
(If "Yes" please specify dates and reasons for taking From____________to_____________, for________________________)

Y N Do you have diabetes? (If "Yes" please specify what type ___________________; Date of diagnosis ____________;
What was your most recent blood sugar reading? _______________; Date last tested __________________)

Is there any other medical or dental information that you feel we should know about?____

I understand that I am responsible for all of the charges for all services rendered to me or any member of my family. I understand an assessment of $50 will be charged to my account if I fail to cancel any appointment without at least 48 hours notice.

Patient Signature or Guardian if child: ____**Date:** ______________________________

Doctor's Signature: ____ **Date:** ______________________________

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www.imagecaredentalgroup.com

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _______________________________ Date of Birth: _______________

I have been given the opportunity to receive IMAGECARE'S Notice of Privacy Practices. I understand that this notice is Federally mandated and that it provides in detail the uses and disclosures of my protected health information that may be made by IMAGECARE, my individual rights and the IMAGECARE'S legal duties with respect to my protected health information. These include, but are not limited to the following:

- A statement that IMAGECARE is required by law to maintain the privacy of protected health information.
- A statement that they are required to follow the terms of the notice currently in effect.
- Types of uses and disclosures that can be made for each of the following purposes: Treatment, Payment, and Health Care Operations.
- A description of other situations where disclosure of protected health information is permitted or required without my consent or authorization.
- A description of uses and disclosures that are prohibited or limited by law.
- A description of disclosures that require my written authorization and how I may revoke authorizations.
- My individual rights with respect to protected health information and how I can exercise those rights in relationship to:
- The right to complain to IMAGECARE and to the Secretary of HHS if my privacy rights have been violated and that no retaliatory actions will be taken because of such a complaint.
- The right to request restrictions of certain uses and disclosures of my protected health. However, I understand that IMAGECARE does not have to agree to honor my requested restrictions.
- The right to receive confidential communications of protected health information
- The limited right to inspect and copy certain protected health information.
- The right to request to amend protected health information.
- The right to request an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from IMAGECARE upon request.

I also understand the IMAGECARE reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions for all protected health information that it maintains. Furthermore, if changes are made, I can obtain a revised Notice of Privacy Information upon request.

Signature: ____________________________________ Date: ________________________

Relationship to Patient {if signed by a personal representative of patient}

____

If you would like to authorize a person or persons to be able to talk about your treatment or account, please sign below.

My treatment and account status may be discussed with ______________________________(name)

____________________________(relationship). _______________date

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We're Committed to Handling the Financial End with You in Mind!

In order to maintain an ongoing, positive relationship with our patients, we would like to disclose our options for financing procedures for your dental health.

Payment in full is required at the time services are rendered.

If you have an insurance plan that our office can accept, we will be glad, as a courtesy, to file to the insurance company for your benefits. We will estimate your copay based on information we obtain from your insurance company. This co pay is expected at the time services are rendered. If the insurance company pays less than expected or not at all, we will be glad to bill you for the balance. This payment is expected in full upon receipt.

Please make sure we have your most current insurance information on file. Refiling of claims will be subject to a $25 refile fee.

If you would like to take advantage of CareCredit, we can help you in your application. This service allows you to pay out your dental health services over a period of up to 12 months, depending on the cost of your treatment.

> ***For the comfort and convenience of our patients, we ask for payment to be made on the day of appointment prior to being seated for treatment in the operatory. This allows our patients to take care of financial arrangements while not under the influence of anesthesia or sedation. After a dental procedure, it is comforting to know that you will be able to leave immediately after your visit without standing in the business area waiting on our financial staff.***

We accept Visa, American Express, MasterCard and Discover. We also welcome your personal checks with proper identification.

We thank you for your cooperation in our financial policy. We are dedicated to your oral health and will help you in any way we can.

I have read and understand Imagecare Dental's financial policy.

____

Signature date

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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 factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk 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 that using 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 life. 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.

The fee for this enhanced examination is $49.00

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: ________________