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**Welcome Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Thank you for selecting our team to provide you with the best oral care!

To help us meet all your concerns, please fill out this form completely so we can start your dental records.

Patient’s name: Mr./Ms./Mrs.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact name & phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber/Responsible Person(if different than patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_: Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Dental Insurance;Company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Dental Insurance; Company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any pain/discomfort: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last dental visit: \_\_\_\_\_\_\_\_\_\_\_\_ Last dental x-rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Happy with your smile? \_\_\_\_\_\_\_\_\_\_\_\_

Health Information; Physician’s name& phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications that you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any drug allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Latex: \_\_\_\_\_\_\_\_\_\_ Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any surgeries or hospitalizations& approximate dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please put a checkmark by any of the following medications if you are using any:

Fosamax \_\_\_ Didronel \_\_\_Boniva \_\_\_ Aredia \_\_\_ Actonel \_\_\_ Skelid \_\_\_ Zometa \_\_\_

Do you use Tobacco? \_\_\_ How much? \_\_\_\_\_\_\_\_ How used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used or are currently using any recreational drugs? \_\_\_\_\_\_\_\_\_\_

For Women: Any birth control pills? \_\_\_\_ Which one? \_\_\_\_\_\_\_\_

Are you pregnant? \_\_\_\_\_\_ Approximate Delivery date: \_\_\_\_\_\_\_\_\_\_\_ Are you nursing? \_\_\_\_\_\_\_\_\_

Please put a check mark by any of the below diseases or medical conditions if you have or had them:

|  |  |
| --- | --- |
| 🞎 Alcohol Drug Abuse  🞎 Aggressive Steroid Therapy  🞎 Anemia  🞎 Asthma  🞎 Artificial Bones/Joints  🞎 Artificial Valves  🞎 Bleeding Problems  🞎 Cancer  🞎 Chemotherapy  🞎 Chest Pain  🞎 Congenital Heart Defect  🞎 Defibrillator  🞎 Diabetes/Hypoglycemia  🞎 Difficulty Breathing  🞎 Emphysema  🞎 Epilepsy  🞎 Fainting/Seizures  🞎 Frequent Headaches  🞎 Frequent Neck Pain  🞎 Glaucoma  🞎 Heart Attack  🞎 Heart Disease Heart Murmur  🞎 Heart Surgery | 🞎 Hepatitis  🞎 High Blood Pressure  🞎 HIV +/AIDS/ARC  🞎 Jaw problems TMJ  🞎 Joint Replacement  🞎 Kidney Problems  🞎 Leukemia  🞎 Liver Problems  🞎 Lupus  🞎 Mitral Valve Prolepses  🞎 Osteoporosis  🞎 Pacemaker  🞎 Psychiatric Problems  🞎 Rheumatic Fever  🞎 Rheumatoid Arthritis  🞎 Scarlet Fever  🞎 Sinus Problems  🞎 Stents/Shunts  🞎 Stomach Ulcer  🞎 Stroke  🞎 Tuberculosis TB  🞎 Venereal Disease  🞎 High Cholesterol |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X-rays: We pride ourselves in delivering the highest standard of care; therefore complete diagnostic x-rays are necessary. We require complete series of X-rays on our patients. If you have had any recent x-rays done with another dentist office, please provide us with a copy so we will not repeat them.

Notice to test blood: A law was enacted in Virginia in 1989 which authorized healthcare providers to test their patients for HIV antibodies when the healthcare provider is accidentally exposed to blood or body fluids in a manner which may transmit the human auto immune deficiency virus (HIV). However you would be informed before any of your blood would be tested for HIV antibodies. The testing would be explained and you would be given the opportunity to ask any questions you might have. In addition, in the event that one of our healthcare providers is exposed to potentially infectious body fluids, permission is hereby granted to test my blood for infectious Hepatitis B.

Please read and initial:

\_\_\_\_\_\_Financial Policy: It is the goal of our practice to provide you with the finest oral care and financial services. Patients will be scheduled for treatment after financial arrangements are made. Our financial associates are available to answer any questions you have.

\_\_\_\_\_\_Insurance policy: Patients are expected to pay their portion of insurance agreement including the co-pay and deductibles. As a courtesy to all of our patients with insurance, we will file dental services with primary insurance company, and if applicable with secondary insurance. The normal time allowed for insurance response is 30 days. Any charges remaining on patient account after the insurance coverage are ultimately patient’s responsibility.

\_\_\_\_\_\_Payment Policy: Our office requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the financial department. When other arrangements are made, patient authorizes Galleria Dental to make such inquires with any credit bureau regarding financial responsibilities that are deemed necessary.

\_\_\_\_\_\_Short Notice Cancelation: Our practice requires a 24-business hour, notice if you are not able to make your appointment. Without your notice, a $50.00/per hour of scheduled treatment, a cancelation fee will be charged to your account.

Patient Authorizations: \_\_\_\_\_I authorize Galleria Dental to perform, including but not limited to restorative, oral surgery, periodontics, endodontics, and replacement of missing teeth. I understand that further information for my individual needs will be provided rendering of treatment any necessary services needed during diagnosis and treatment. I also authorize the release of any required information to outside health practitioners and for the purpose of processing insurance claims.

\_\_\_\_\_I understand that my insurance policy is a contract between me and my insurance company (ies) and that I am responsible for all fees. Collection Fees will be applied for all delinquent accounts.

\_\_\_\_\_I authorize and request my insurance company (if applicable) to pay dental benefits directly to Galleria Dental Arts otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual billed services and that I am responsible for the remaining balance.

\_\_\_\_\_I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Power of Attorney \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Oral Cancer and VELscope**

*As you may know, we conduct an oral health examination during every patient’s annual hygiene check-up. Now we can do an even better job of this, because our practice has recently invested in a wonderful new screening device called the VELscope. This device allows us to check for a wide variety of things, including inflammation, infections, and even cancerous and precancerous tissue.*

*There is a slight charge for this screening—$20—. However, we strongly recommend that all patients have this screening.*

*So, may we proceed with the screening? \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_*

*Print patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Perhaps the most important reason to do this screening is the fact oral cancer is more prevalent than most people realize. In fact, it strikes over three times as many people as cervical cancer. And, unlike most other forms of cancer, the incidence of oral cancer is actually growing each year. One reason for this is that certain strains of sexually-transmitted HPV are now known to cause oral cancer.*

*Another reason it’s important for all adults to have an annual oral cancer screening is the fact that if oral cancer is detected in early stages, the five-year survival rate can be 80% or even higher. If it’s detected in late stages, however, the survival rate is only around 20%.*

*Fortunately, the odds are that you don’t have oral cancer—or any other oral disease—but this screening helps us—and you—be sure. The VELscope device allows us to see things we haven’t been able to see before, which means that if you do have something that concerns us, there’s a much better chance that we’ll catch it at an early stage. The procedure adds only about a minute to our normal exam, and it’s totally pain-free and comfortable.*

*If we do discover something, you should know that it isn’t necessarily oral cancer. It could simply be some trauma that results from some other irritation, such as if you chew the inside of your cheek or if you recently ate some real hot food. However, if what we see does cause us some concern, we will generally ask you to come back in a few weeks so we can observe it again. If it hasn’t improved, we’ll probably do a biopsy and have it evaluated by a pathologist. If the evaluation indicates that what you have is cancerous or precancerous, we would then refer you to specialists who will be able to provide the necessary treatment.*

*Again this screening is just a smart precaution—just as annual mammograms, Pap smears and prostate exams are.*