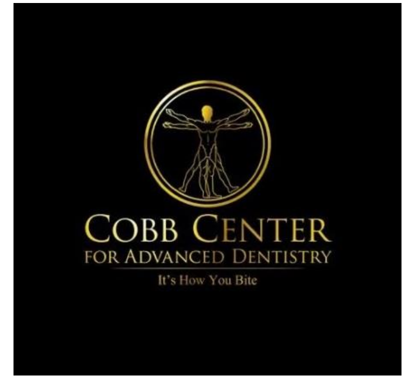

Sanjay Patel, D.M.D.

Patient Name:____ *Prefer to be called:*____________________

*Female Male Date of Birth*_____/_____/_____ *SSN#*_____/_____/_____ *Marital Status:*_____________

*Address:*____*City*______________*State*______*Zip*_________

*Cell:*______________________ *Home:*___________________ *Email:*________________________________

*Employer*____ *Work Phone:*__________________________

*Address:*____*City*______________*State*______*Zip*_________

Emergency Contact:________________________________ Phone_______________ Relationship ____________

Responsible Party:________________________________ Phone_______________ Relationship _____________

*Address:*____*City*______________*State*______*Zip*_________

*Female Male Date of Birth*_____/_____/_____ *SSN#*_____/_____/_____ *Marital Status:*_____________

Insurance Company:____*Phone*______________________

*Address:*____*City*______________*State*______*Zip*_________

*Subscriber ID#*______________________________________*Group#*______________________________________

---

*Are you currently under the care of a physician**:** **Yes** **No** Dr. Name*____________________________ *Phone*___________________

*If yes, for what condition*____

Have you had surgery within the past 6 weeks: ***Yes No*** *Explain:*____

Are you currently taking prescription or over the counter drugs or herbal supplements: ***Yes*** ***No***

*Are you on an Aspirin therapy regime**:** **Yes No** If yes please Explain:* ***81 mg/day*** *or other*________________________________

Are you currently on any blood thinning therapy: ***Yes No*** *If yes please Explain:*____

Do you take Ginger, Ginseng, Ginko Biloba or Garlic: ***Yes No*** *If yes please list which ones:*_________________________________

Please list all medications you are currently taking. Please include all prescribed medications as well as any over the counter medications:

Name of Medication	Dosage (mg.)	Frequency (1/day, 2/day)	Prescribing Doctor	Phone #

Special circumstances we should be aware of:

____

Do you have Allergies to any of the following:

Aspirin	**Yes**	**No**	**Local Anesthetic**	**Yes**	**No**	**Latex**	**Yes**	**No**
Codeine	**Yes**	**No**	**Penicillin**	**Yes**	**No**	**Sulfa**	**Yes**	**No**
Erythromycin	**Yes**	**No**	**Antibiotics**	**Yes**	**No**	**Barbiturates**	**Yes**	**No**
Sleeping Pills	**Yes**	**No**	**Sedatives**	**Yes**	**No**	**Plastic**	**Yes**	**No**
Iodine	**Yes**	**No**	**Metals**	**Yes**	**No**			

Other:____

Are you currently a patient at a pain management group: **Yes** **No** Reason:_________________________________

Group Name:____ Phone:_________________________________

Do you require Oral Premedication with antibiotics before dental treatment: **Yes** **No**

If yes for what condition:_____________________________________ Medication____________________Dosage__________

Have you ever taken any of the groups of drugs collectively known as “fen-phen”: **Yes** **No** When:______________

Were you medically cleared of any heart issues: **Yes** **No** Was there heart damage: **Yes** **No**

Please explain if yes:____

Do you or have you ever used:

Tobacco Yes No If yes please list frequency:____

Alcohol Yes No If yes please list frequency:____

Recreational Drugs Yes No If yes please list frequency:____

When was your last dental appointment:__________________________________ Reason:______________________________

Do you have a history of gum disease: **Yes** **No** Was it treated with Deep Cleaning or Surgery: **Yes** **No**

Please circle either Y if you have had or N if you have not had any of the following:

Condition			Condition			Condition		
Aids/HIV	**Yes**	**No**	Anemia	**Yes**	**No**	Arthritis	**Yes**	**No**
Artificial Heart Valves	**Yes**	**No**	Artificial Joints	**Yes**	**No**	Asthma	**Yes**	**No**
Back Problems	**Yes**	**No**	Bleeding Issues	**Yes**	**No**	Blood Disease	**Yes**	**No**
Cancer	**Yes**	**No**	Chemotherapy	**Yes**	**No**	Circulatory	**Yes**	**No**
Cortisone Treatment	**Yes**	**No**	Cough Persistent	**Yes**	**No**	Coughing Bloody	**Yes**	**No**
Diabetes	**Yes**	**No**	Drug Addiction	**Yes**	**No**	Emphysema	**Yes**	**No**
Epilepsy	**Yes**	**No**	Fainting/Dizziness	**Yes**	**No**	Glaucoma	**Yes**	**No**
Heart Lesions	**Yes**	**No**	Headache/Migraine	**Yes**	**No**	Heart Murmur	**Yes**	**No**
Heart Problems	**Yes**	**No**	Hepatitis Type ____	**Yes**	**No**	Herpes	**Yes**	**No**
High Blood Pressure	**Yes**	**No**	Jaundice	**Yes**	**No**	Jaw Pain	**Yes**	**No**
Kidney Disease	**Yes**	**No**	Liver Disease	**Yes**	**No**	Nervous Issues	**Yes**	**No**
Low Blood Pressure	**Yes**	**No**	Mitral Valve Disease	**Yes**	**No**	Pacemaker	**Yes**	**No**
Psychiatric Care	**Yes**	**No**	Radiation Treatment	**Yes**	**No**	Rheumatic Fever	**Yes**	**No**
Respiratory Disease	**Yes**	**No**	Scarlet Fever	**Yes**	**No**	Skin Rash	**Yes**	**No**
Shortness of Breath	**Yes**	**No**	Sinus Trouble	**Yes**	**No**	Special Diet	**Yes**	**No**
Swollen feet or ankles	**Yes**	**No**	Swollen Glands	**Yes**	**No**	Stroke	**Yes**	**No**
Thyroid Problems	**Yes**	**No**	Tumor Growth on head	**Yes**	**No**	Tonsillitis	**Yes**	**No**
Ulcers	**Yes**	**No**	Venereal Disease	**Yes**	**No**	Weight Loss	**Yes**	**No**
Adnoids Removed	**Yes**	**No**	Anemia	**Yes**	**No**	Arteriosclerosis	**Yes**	**No**
Autoimmune Disorders	**Yes**	**No**	Bleeding Easily	**Yes**	**No**	Bruising Easily	**Yes**	**No**
Chronic Fatigue	**Yes**	**No**	Cold Hands and Feet	**Yes**	**No**	Dizziness	**Yes**	**No**
Difficulty Concentrating	**Yes**	**No**	Excessive Thirst	**Yes**	**No**	Fluid retention	**Yes**	**No**
Frequent cough	**Yes**	**No**	Frequent Illness	**Yes**	**No**	Hypoglycemia	**Yes**	**No**
Frequent stressful situations	**Yes**	**No**	Fibromyalgia	**Yes**	**No**	Gout	**Yes**	**No**
Hearing Impairment	**Yes**	**No**	Heart Palpitations	**Yes**	**No**	Hemophilia	**Yes**	**No**
Immune System Disorder	**Yes**	**No**	Insomnia	**Yes**	**No**	Liver Disease	**Yes**	**No**
Intestinal disorders	**Yes**	**No**	Jaw Joint Surgery	**Yes**	**No**	Menieres Disease	**Yes**	**No**
Menstrual Cramps	**Yes**	**No**	Multiple Sclerosis	**Yes**	**No**	Muscle Aches	**Yes**	**No**
Muscle Shaking	**Yes**	**No**	Muscle Spasms	**Yes**	**No**	Muscle Cramps	**Yes**	**No**
Muscular Dystrophy	**Yes**	**No**	Nervous System Irritability	**Yes**	**No**	Nervousness	**Yes**	**No**
Neuralgia	**Yes**	**No**	Osteoarthritis	**Yes**	**No**	Osteoporosis	**Yes**	**No**
Ovarian Cysts	**Yes**	**No**	Parkinsons Disease	**Yes**	**No**	Poor Circulation	**Yes**	**No**
Braces	**Yes**	**No**	Radiation Treatment	**Yes**	**No**	Skin Disorder	**Yes**	**No**
Shortness of breath	**Yes**	**No**	Slow Healing sores	**Yes**	**No**	Speech Difficulties	**Yes**	**No**
Swollen, stiff or painful joints	**Yes**	**No**	Tired Muscles	**Yes**	**No**	Tumors	**Yes**	**No**
Urinary Disorders	**Yes**	**No**	Wisdom Teeth Removal	**Yes**	**No**			
Injury to: Face	**Yes**	**No**	**Tendency for**:					
Neck	**Yes**	**No**	Frequent Colds	**Yes**	**No**	**Other:** ________________		
Mouth	**Yes**	**No**	Ear Infections	**Yes**	**No**	______________________		
Teeth	**Yes**	**No**	Sore Throats	**Yes**	**No**	______________________		

This section is for women only

Are you currently pregnant **Yes** **No** If yes what week___ Dr. Name________________________________

Are you Nursing **Yes** **No**

Are you taking Birth Control **Yes** **No** Phone__________________________________

To better coordinate your treatment, please list the medical professionals you have consulted regarding your present symptoms. Please be sure to list your primary physician and family dentist if not Dr. Patel

______ *Please initial* if you want us to send them a report from your visit.

Patient Name:________________________________ Date:____________________________________

Family Physician

Name:____
Address:____
____
Phone:____

Dentist

Name:____
Address:____
____
Phone:____

Chiropractor

Name:____
Address:____
____
Phone:____

Physical Therapist

Name:____
Address:____
____
Phone:____

ENT - Allergist

Name:____
Address:____
____
Phone:____

Cardiologist

Name:____
Address:____
____
Phone:____

Pulmonologist

Name:____
Address:____
____
Phone:____

Neurologist

Name:____
Address:____
____
Phone:____

Psychiatrist

Name:____
Address:____
____
Phone:____

Psychologist

Name:____
Address:____
____
Phone:____

Other

Name:____
Address:____
____
Phone:____

Pain Management Group

Name:____
Address:____
____
Phone:____

_____ I understand and agree to have the indicated professionals I have listed above be sent initial information and ongoing updates regarding my diagnoses and treatment.

_____ I *do not wish* to have my records sent at this time.

____DATE_____________________________
Patient or Guardian Signature

Head, Neck and Facial Pain Questionnaire

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please number your complains with the 1 being most severe symptom, 2 the next, etc.
2. Then rate your complaints for frequency and intensity:

   1 - Seldom   2 - Occasional   3 – Frequent   4 – Every Day

3. Intensity: 0 = No Pain   5 = Bad but can function   10 = MOST SEVERE PAIN

Number		Frequency	Intensity
_____	Back Pain	_______	_______
_____	Dizziness	_______	_______
_____	Ear Congestion	_______	_______
_____	Ear Pain	_______	_______
_____	Eye Pain	_______	_______
_____	Facial Pain	_______	_______
_____	Fatigue	_______	_______
_____	Headaches	_______	_______
_____	Inability to open mouth	_______	_______
_____	Jaw Clicking	_______	_______
_____	Jaw Joint Noises	_______	_______
_____	Jaw Locking	_______	_______
_____	Jaw Pain	_______	_______
_____	Limited Mouth Opening	_______	_______
_____	Migraine Headaches	_______	_______
_____	Muscle Twitching	_______	_______
_____	Neck Pain	_______	_______
_____	Pain when chewing	_______	_______
_____	Ringing In the Ears	_______	_______
_____	Shoulder Pain	_______	_______
_____	Sinus Congestion	_______	_______
_____	Throat Pain	_______	_______
_____	Visual Disturbances	_______	_______
_____	Other:_____________________________	_______	_______

Fill In

____ Date:____________________

Signature of patient completing form

Please list any treatments you have had for this problem:

1.____Date________________
2.____Date________________
3.____Date________________

Symptoms: Please indicate location and type of pain.

Jaw Symptoms

Jaw Clicks	**Yes**	**No**	Jaw Locks Closed	**Yes**	**No**	Jaw Popping	**Yes**	**No**
Jaw Locks Open	**Yes**	**No**	Teeth Clenching	**Yes**	**No**	Teeth Grinding	**Yes**	**No**

Eye Related Conditions

Blurred Vision	**Yes**	**No**	Double Vision	**Yes**	**No**	Eye Pain	**Yes**	**No**
Pain or pressure behind the eyes	**Yes**	**No**	Photophobia	**Yes**	**No**			

Ear Related Conditions

Buzzing in ears	**Yes**	**No**	Ear Congestion	**Yes**	**No**	Ear Pain	**Yes**	**No**
Hearing Loss	**Yes**	**No**	Pain behind ear	**Yes**	**No**	Tinnitus	**Yes**	**No**
Pain in front of ear	**Yes**	**No**	Recurrent Ear Infections	**Yes**	**No**			

Throat, Neck and Back Related Conditions

Back Pain - Lower	**Yes**	**No**	Chronic Sore Throat	**Yes**	**No**	Neck Pain	**Yes**	**No**
Back Pain - Middle	**Yes**	**No**	Difficulty Swallowing	**Yes**	**No**	Limited Movement	**Yes**	**No**
Back Pain – Upper	**Yes**	**No**	Scoliosis	**Yes**	**No**	Sciatica	**Yes**	**No**
Numbness in hands or fingers	**Yes**	**No**	Shoulder Stiffness	**Yes**	**No**	Swollen Glands	**Yes**	**No**
Swelling in Neck	**Yes**	**No**	Thyroid Enlargement	**Yes**	**No**	Wryneck	**Yes**	**No**
Tightness in Throat	**Yes**	**No**	Tingling in hands fingers	**Yes**	**No**			

Mouth and Nose Related

Broken Teeth	**Yes**	**No**	Burning Tongue	**Yes**	**No**	Dry Mouth	**Yes**	**No**
Chronic Sinusitis	**Yes**	**No**	Frequently biting Cheek	**Yes**	**No**	Frequent Snoring	**Yes**	**No**

Please Indicate Location and Type of Any Head Pain: L = Left R = Right B = Both Sides

Head Pain	Location		SEVERITY			FREQUENCY			DURATION				
			MILD	MODERATE	SEVERE	Monthly	Weekly	Daily	Seconds	Minutes	Hours	Days	Weeks
L R B	Front of head	(Frontal)	0	0	0	0	0	0	0	0	0	0	0
L R B	Entire Head	(Generalized)	0	0	0	0	0	0	0	0	0	0	0
L R B	Top of Head	(Parietal)	0	0	0	0	0	0	0	0	0	0	0
L R B	Back of Head	(Occipital)	0	0	0	0	0	0	0	0	0	0	0
L R B	In the Temples	(Temporal)	0	0	0	0	0	0	0	0	0	0	0

Jaw Pain

L R B Jaw Pain – On Opening
L R B Jay Pain – While Chewing
L R B Jay Pain – At Rest

History of Symptoms

When did you condition first occur?:______________________________
____

Do you believe is the cause of your pain or condition?

___ Motor Vehicle Accident
___ Athletic Endeavor
___ Fall
___ Injury
___ Motorcycle Accident
___ Playground Incident
___ Accident
___ Unknown
___ Work Related Incident
___ Fight
___ Illness
___ Other:___________________________
If accident, date:______________________

Is there anything that makes your pain or discomfort worse?____

Is there anything that makes your pain or discomfort better?:____

What other information is important to your pain or condition?"_____________________________________

____

Family History

Have any members of your family (blood kin) had:

___ Headaches ___ Heart Disease ___ High Blood Pressure ___ Diabetes

Social History

Occupation: _______________________________________ Is your job stressful: **Yes** **No**

Do you have children: **Yes** **No** If so how many: _________ What are their ages?: ______________

Are you currently under unusual stress **Yes** **No** If a smoker how much per day?: _______________________

Recent change in lifestyle **Yes** **No** Caffeine drinks per day?: _____________________________

Do you Chew Tobacco **Yes** **No** Alcohol consumption:

Do you exercise regularly? **Yes** **No** __ None __ Daily __ Social Drinker __ Occasional Only

History of Accident: If you were involved in an accident or a traumatic incident, complete this section

Date of Incident or accident: ____________________________

WERE YOU?

____ A passenger in a vehicle
____ The driver of a vehicle
____ A Pedestrian
____ At work

AND…

____ Did you fall
____ Were you hit by an object
____ Did you hit an object
____ Other:_____________________________

Indicate if there was any direct trauma:

DID YOUR

____ Forehead
____ Face
____ Chin
____ Side of head
____ Back of head
____ Top of head
____ Teeth
____ Jaw
____ Roof
____ Other:_____________________________

FORCIBLY STRIKE

____ Steering Wheel
____ Windshield
____ Passengers side window
____ Drivers side window
____ Passengers side door
____ Drivers side door
____ Headrest
____ Seat
____ Interior of car
____ Other:_____________________________

Were any areas of your body painful shortly after the accident/incident?

____	Head	____	Neck	____	Face	____	Right Arm
____	Jaw	____	Left Shoulder	____	Right Shoulder	____	Left Arm
____	Lower Back	____	Upper Back	____	Other:________________________________		

Did you go to the Hospital?: **Yes** **No** Which Hospital?:_____________________________

By Car **Yes** **No** Were X-Rays taken **Yes** **No**

By Ambulance **Yes** **No** Release date: _______________________________

Has a Doctor ever diagnosed a TMJ or TMD disorder prior to the accident? **Yes** **No**

If yes, please explain: ____

____

____

Signature: ____ Date: _______________________

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN	|||||||	B Burning D Dull
MODERATE PAIN	ΛΛΛΛ	N Numbing P Pressure S Sharp
SEVERE PAIN	//////	T Tingling R Radiating

EXAMPLE

Patient Signature ______________________ Date ______________

Acknowledgement of receipt of notice of Privacy Practices

-
- You may refuse to sign this acknowledgement

I, ____, have received a copy of this offices Notice of Privacy Practices

____
Printed Name

____
Signature

____
Date

(***Please initial either giving permission or not giving permission below***)

Name	Phone Number/Email	Relationship
________________________________	________________________	_____________
________________________________	________________________	_____________
________________________________	________________________	_____________

_____ I ***give permission*** to Cobb Center for Advanced Dentistry to discuss my case, health and care, in emergency and nonemergency instances, via phone, in person or via email and mail posted USPS with the following:

OR

_____ I ***do not give permission*** any information regarding my case, health and care to be discussed with any person except my dental insurance provider and other medical professionals involved in my treatment.

For Office Use Only Do not write below this line

We attempted to obtain written acknowledgement from the patient that they did receive a copy of the Notice of Privacy Practice, but were unable to due to:

_____ The individual refused to sign
_____ Communication barriers prevented obtaining the acknowledgement
_____ Emergency situation prevented us from obtaining the acknowledgement
_____ Other (Please Detail Situation)____
____

____ Date _________________________
Signature

WE ARE ***NOT IN NETWORK*** *WITH ANY INSURANCE COMPANY*

Dear Patients,

Due to the fact that at Shallowford Dental we strive to provide patients with the best care possible, it is also our duty to inform our patients that we are *NOT "In Network"* with any insurance companies as we feel that they do not have our patients best interest at heart, often prescribing cheaper treatment options that may not be a permanent solution to the problem at hand.

We have found that there is usually little to no difference in coverage provided by the insurance companies, however your "Dental Insurance" is a contract between you and the insurance company we are a 3rd party to the contract as a result.

Please initial each section below and sign.

_____ ***We collect 100% of our fees at the time of service. The insurance has 14 business days to reimburse you by law***.

_____ *Shallowford Dental can only provide the patient with* an *"Estimate" of expected coverage, but it is not a guarantee of payment the only way to get exact amounts is for the patient or guarantor to call the insurance company and get the information. They will not reveal this information to our office.*

_____ *As a courtesy Shallowford Dental will submit your insurance for you. If the insurance denies the claim it is the responsibility of the patient or guarantor to contact the insurance company as the policy is a contract between the patient and the insurance company and they will give you the answers you require.*

_____ *If no insurance is in effect the total amount is the responsibility of the patient or guarantor.*

In signing this document I acknowledge I understand the insurance policy as stated above and understand my responsibility

____Date_______________

Patient or Guarantor Signature

No-Show Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.

Definition of a "No-Show" Appointment Shallowford Dental defines a "No-show" appointment as any scheduled appointment in which the patient either:

- O Does not arrive to the appointment
- O Cancels with less than 48 hours notice
- O Arrives more than 10 minutes late and is consequently unable to be seen

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- O Potentially jeopardizes the health of the “no-showing” patient
- O Is unfair (and frustrating) to other patients that would have taken the appointment slot
- O Disrespects not only the provider’s time, but also the time of the entire clinic staff

How to Avoid Getting a “No-Show”

- O Confirm your appointment by responding yes to your text notification
- O Arrive 5-10 minutes early
- O Give 48 hours notice to cancel appointment

Appointment Confirmation

Shallowford Dental will attempt to contact you via automated text and emails 1 week, then 2 days prior to your scheduled appointment to confirm your visit. Respond with your confirmation by texting “YES” If you are unable to respond via text or email, you will need to contact Shallowford Dental by 2:30pm the business day before the appointment – otherwise the appointment will be canceled and marked as a “no-show”.

Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we request you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.

Give 48 Hours’ Notice if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we request you to contact our office no later than 48 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us a courtesy phone call.

Consequences of “No-Show” Appointments

If you miss 3 or more appointments within a year you may be dismissed from the practice.

1. Patient dismissal is at the discretion of your dental provider
2. If you are dismissed from the practice, your remaining scheduled appointments will be cancelled
3. Only emergency dental treatment will be offered within the first 30 days of dismissal
4. Reapplication to the practice after a six month period after initial dismissal letter will be considered by your dental provider.

$300.00 Charge for Missed Surgical appointments
$150.00 Charge for Missed Hygiene appointments
$ 25.00 Charge for missed post op and recheck appointments.

These charges are solely the responsibility of the patient and cannot be billed to your insurance. All missed appointment charges must be paid in full prior to scheduling your next dental appointment.

SIGNATURE: ____DATE:________________________________

Office Policy and Guidelines

Please read and initial each statement below and sign

_____ *Payment in full is expected at the time services are rendered unless other arrangements are made in advance. For your convenience, we do accept the following types of payment: Cash, Check, Visa, Master Card, Discover and American Express*

_____ *Since a wide variety of services are available in our office, we have no uniform policy that covers all procedures and treatments.*

_____ *Your insurance policy is a contract between you and the insurance company, we have not control or input with the insurance companies, however, we will assist you by filing your to primary policy as a courtesy. We will collect 100% of the fee charged on the day services are rendered. You will be responsible for filing your secondary insurance if any. The receipt that we will provide will assist you in filing your secondary insurance.*

_____ *Your insurance company has 14 business days by law to reimburse you. Any questions regarding unpaid balances should be directed to your insurance company directly.*

_____ *Time is valuable for both you and Dr. Patel. Every effort to assist you in making a convenient appointment has been made, if you must cancel please notify us 24 hours PRIOR to your scheduled appointment. If an appointment is broken or cancelled with less than a 24-hour notice there will be a $25 broken appointment fee charged to you. Please be on time for your appointment since ample time has been set aside for your care. If you are 10 minutes late, your appointment will be rescheduled.*

_____ *A service charge of 1.5 % will be added to all accounts 30 days past due. A service charge for returned checks will be added to the account in the amount of $35.00. If this occurs, we will no longer be able to accept checks for your account. Any balance 90 days or older with no activity will be turned over to either the Magistrate Court or a collection agency. Once turned over to the collection agency the patient will be responsible for the additional 25% collection fee due to the agency. It will be your responsibility to pay for any and all court or collection fees and any associated fees such as certified letters.*

In signing this document, I acknowledge that I have read and understand the policies and understand my responsibilities.

____ Date________________________________

Signature of patient or guarantor if patient is a minor

It is our Mission to:

1. Expect and ensure optimal dental health and general wellness for our patients for life.
2. To provide the highest possible quality and value of dental care, with courtesy and professionalism.
3. To deliver this care in a happy, welcoming and protective environment with integrity and empathy.
4. To accept our patients as partners in their wellness through education, motivation and open communication.
5. To respect our patients time.
6. To provide the patient with the most comfortable, fear free and pain free treatment possible and make their dental visits a pleasurable experience.
7. To consistently provide exceptional service and deliver more that your expectations.
8. To pursue excellence through continuing education, personal and team grown, and mastery of cutting-edge technology.
9. To flourish through patient satisfaction and subsequent recommendations to their friends and family.

If you ever feel that we are not living up to our mission, please feel free to bring it to our attention.

Oral Cancer 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 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 for both the incidence and mortality rates of oral cancer to 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 than 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
High Risk: Patients age 40 and older; tobacco users (any age, any type within 10 years)
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 Velscope® into our oral screening standard of care. We find that using Velscope along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. Velscope is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. Velscope is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The Velscope exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam may not be covered by your insurance.

The fee for this enhanced examination is $83.00 this is not covered by your dental insurance.

Yes, *I authorize the clinician to perform the Velscope exam*,
along with the standard oral cancer examination.
I accept financial responsibility for this enhanced examination.

Signature: ____ Date: ________________

OR

No, *I would prefer not have the Velscope exam* done at this time.

Signature: ____ Date: ________________

Cobb Center for Advanced Dentistry

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 (4/1/02), 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 a 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $30 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.
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, costbased fee for responding to these additional requests.
Restriction: 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 a 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 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 (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 you 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 may also 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: Beckysue Jackson
Telephone: 770-578-1331
Fax: 770-578-1325
Address: 3225 Shallowford Rd.
Ste. 520,
Marietta, GA 30062