

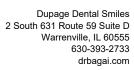


				Ne	w Patient	Form				
	nfidential.		ation to the best of your any questions, plea				Date: / /		Patient #:	
Patier	nt Info	rmatior	n							
Title:	First Na	ame:	Middle Nar	me:	Last Name:			I prefer	to be called	:
Sex:	Age:	Date of	Birth (mm/dd/yyyy)	: Marital Stat	us:	Soci	al Security #:	Driver's	Licence Sta	ate & #:
Home	Phone:	_	Work Phone:	Cell F	Phone:	E-	mail Address:			
Home /	Address:					City:			State:	ZIP Code:
Employ	/ment:	Employe	er's Name:	Emplo	yer's Phone: -	hone: Occupation:				
Employ	er's Add	lress:				City:			State:	ZIP Code:
Studen	t Status:	Sch	ool Name (if a full-t	ime student):		Grade:				ı
			contact you:				Send appoint Text Mes		nders via: Email	Mail
Frie Ad	end or F in Mail arch En	Relative Sa	n heard about us (che (name): nw our Office Google, etc.)		Ne Company	wspape / O	r Ad Radio ur Website	o Ad	TV Ad	
Was o	our web	site a fa	actor in your ded	cision to vis	sit our prac	tice?	Yes No			
			rent, if a minor): Sp		•			ne: Spous	se/Parent Ce	ell Phone:
Other f	amily me	embers tr	eated by us:		Add	ditional Co	omments:			



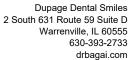


Emer	gency (Contact									
This sh	ould be	the neare	st relat	ive who does no	t live wit	th the patient.					
Title:	First Na	ame:		Last Name:		Relationship to Patient:					
Home F	Phone:	-	Work	Phone:	Cell F	Phone:	E-mail Address:				
Emerge	ency_Co	ntact Add	lress:				City:			State:	ZIP Code:
Perso		onsible	for A	ccount							
Title:	First Na	ame:		Middle Name:		Last Name:			Relationship to Patient:		
Date of	Birth (m	m/dd/yyy	y): So	cial Security #:	Dri	ver's Licence St	tate & #: Holder of Dental Insurance for Patient:				
,	/ /	'									
Home Phone: Work Phone:			Cell F	Cell Phone: E-mail Address:							
Billing Address:					City:			State:	ZIP Code:		
Employer's Name:			Emplo	yer's Phone: -	r's Phone: Occupation:						
Employer's Address:					City:			State:	ZIP Code:		



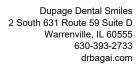


Insurance Informa	tion							g
Primary Insurance								
Insurance Holder's Nam	ne:	Date of B	Birth (mm/dd/yyyy): /	Relationship to	o Patient: Em	nployer:		
Member ID:	Group ID:		Insurance Compa	ny Name:		nsurance C -	ompany -	y Phone:
Insured's SSN:	Ins	urance Com	pany's Address:	City:			State:	ZIP Code:
Secondary Insurance	e							
Insurance Holder's Nam	ne:	Date of B	Sirth (mm/dd/yyyy): /	Relationship to	tionship to Patient: Employer:			
Member ID:	Group ID:		Insurance Compa	ny Name:		nsurance C -	ompany -	y Phone:
Insured's SSN:	Ins	urance Com	pany's Address:	City:			State:	ZIP Code:
Authorization								
insurance submission understand that I am helping me to obtain Smiles. I permit a constitution Smiles, its employed including cell number insurance, or payments.	n responsin payment opy of this es, and/or ers (by phoent.	ble for my from my ir authorizat other ager one call or	bill. I authorize nsurance compa ion to be used ints express prion text message)	Mount Prospanies. I authon place of the roonsent to and email ad	pect Smiles to orize payment e original. I give contact me at	act as my to Mount /e Mount I any/all ph ne purpose	r agent Prospe Prospe none n e of tre	ect ect umbers, eatment,
Signature (Type your na	ame to sign (electronically	v, or print and sign)			Date (m	m/dd/yy /	/yy): '
Consent for Treatm	nent							
Patient Name:								
I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I have read, understood, and agree to the above treatment policy.								
Signature (Type your name to sign electronically, or print and sign):						Date (m	m/dd/yy /	/yy): /





VV					dr	rbagai.con
		Pay	yment			
Does the person	responsible for	r the account already	have an accou	nt with this office?	Yes No	
Payment Metho	d					
Notice: Payment is o		service unless alternative	arrangements hav	ve been made in advance	e. Please choose	· a
Payment in Full						
Cash						
Check						
Credit Card	Type:	Credit Card Number:	Expiration:	Card Verification Coc VISA/MC/Discove AmEx: 4-digit cod	er: 3-digit code printed o	on back
	Your credit ca	rd information is kept	on file for outst	anding account bala	nces.	
Payment Plans						
Start treatment imm	ediately and pay o	over time with low monthly	y payments.			
CareCredit	 Pay fo As long and the interest Low-Interest Enjoy The 14 and low 	r treatment over 6 or g as you pay the low e balance in full by the will be charged on y Payment Plans low monthly payment w minimum monthly pent fees of \$1000.00	minimum month ne end of the pro your purchase. ts with the 24, 30 an average cred payments possib	nly payment each mo omotional 6- or 12-m 6, 48, or 60 month e dit cards and makes ole. This option is av	onth term, no xtended plans convenient, fix railable for	ked,





Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a \$25.00 service fee.

Service Charge

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of \$2.50 for a minimum balance of \$25.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. Please be advised that there is a \$50.00 fee charged for missed or broken appointments without 24 hours notice. To avoid this charge, kindly give us a minimum of 24 hours notice for any appointment cancellation. Feel free to contact us at any time with questions you may have.

X-Ray/Records Release

There is a fee of \$25.00 for any release of X-rays and/or records.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I hereby authorize payment directly to Mount Prospect Smiles of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Mount Prospect Smiles to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
	/ /





	Dental l	History				
Previous Dentist						
Dentist Name:	Dental Practice	Name:		Phone:	-	
Address:		City:			State:	ZIP Code:
What did you like about your last dentist?		What caused yo	ou to leave your la	st dentist?		
Last Dental Visit						
Last Dental Visit (m/y): What were you treated	d for?				atment o	complete? No
What was done at your last dental visit?		Last X-Rays: /	Last Full-Mou	th X-Rays:	Last C	leaning: /
Dental Hygiene						
How often do you visit a dentist? Do you br	ush your teeth? If	yes, how often?	? Do you floss?	If yes, how	often?	
Please list other dental hygeine aids (Interplak,	toothpicks, etc.) to	hat you use:	Are you interested	in regular h	nygiene	cleanings?
Today's Visit						
Do you have any dental problems, pain, or disc	omfort at this time	? If yes, please	describe:			
What is the main reason for your visit today? Tooth Pain Check-up Clean Sedation Dentistry Restorative D	•	ning Cosr ther:	metic Dentistry			
What would you like to learn more about? Whitening Cosmetic Dentistry Dentures Other:	Sedation De	entistry Im	nplants Bri	dges	Venee	ers
Dental Concerns						
Check all that apply. Teeth						
Crooked Loose tee Decay Tooth pai Difficulty chewing Food trap	n	Missing to Mouth sor Sensitive Sensitive Sensitive	res to cold	Blister	s on lip	sweets os/mouth treatment mouth
Gums						
Bad breath Abscesse Red (discolored) Bleeding	d	Sore Swollen		Reced Period	•	reatment



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Facial/Jaw Pain			
Frequent headaches	Pain in temples	Jaw injury	Pain around ear
Avoid certain foods	Jaw locks open/closed	Head injury	
Popping/clicking	Pain in jaw	Neck injury	
Other Concerns			
Smoking/dipping	Orthodontic trea	ıtment	Snoring
Biting cheeks or lip	Burning tongue		Teeth straightening
Popping/clicking	Tooth replacem	ent	Retainer
TMJ	Fractured tooth	syndrome	Dry mouth
Tooth-colored fillings	CPAP		Wisdom teeth extraction
Wisdom teeth	Implants - Tooth	n #:	Cosmetics
Nail-biting	Jaw locks open	closed	Smile makeover
Sleep apnea	Stain		Dental phobias
Limited orthodontics	Chew on one si	de	
Does food tend to get caught be	tween your teeth? If yes, where?		
Do you hold foreign objects (per	ncils, pipe, pins, nails, fingernails,	etc.) with your teeth?	If yes, what?
	-	-	-

Have	von	ever	had:
	you	CICI	mu.

Check all that apply.

Orthodontic treatment Periodontal treatment Your bite adjusted

Oral surgery Your teeth ground A bite plate or mouth guard

Any canker sores or cold sores on your lips, tongue, gums, or body

A serious injury to the mouth or head? If yes, please describe including cause:

A contract injury to the incution nead. If yee, produce describe including educe.					
Ratings					
1 2 3 4 5	On a scale of 1-5 (1 bad, 5 good), please rate how you feel your overall dental health is.				
1 2 3 4 5	On a scale of 1-5 (1 bad, 5 faithful), over the last ten years, rate how faithfully you have had your teeth cleaned.				
1 2 3 4 5	procedures?				
1 2 3 4 5	appointments?				
1 2 3 4 5	On a scale of 1-5 (1 unhappy, 5 very happy), rate how you feel about the look of your smile.				
1 2 3 4 5	On a scale of 1-5 (1 poor, 5 great), how do you rate your quality of sleep?				
1 2 3 4 5	On a scale of 1-5 (1 being low, 5 being high), if you snore, how would you rate the severity of your snoring?				





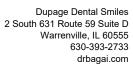
Miscellaneous								
Has fear ever been an issue for you in a dental office? Yes No								
Has time ever been a factor in getting your dental work done? Yes No								
Has the cost of dental treatment been a c	concern for you?	res No						
If yes, how can we help?								
Tell us about your good dental experiences/visits	Tell us a	about your bad	dental experiences/fe	ears:				
What do you like most about your teeth/smile?								
Is there anything you don't like about your teeth/s	mile?							
Is there anything you'd like to change about your	teeth/smile?							
What are your long-term dental goals? How would	d you like your teeth to f	eel and look?						
What are your short-term dental goals?								
Do you have any upcoming event or circumstance yes, what and when?	es (such as weddings, n	najor surgeries,	etc.) we should/need	to know about	t? If			
Is there anything else you feel we should know?								
	Medical Histor	y						
How is your general health? Good	Fair Poor							
Are you currently under medical treatment? If yes	s, what for?							
Do you require antibiotic pre-medication for your	dental work? If yes, wha	t for?						
Physician's Name:	Phone:	Last Visit:						
Address:		City:		State: ZIP C	ode:			
Do we have permission to contact your d	octor regarding your	care? Ye	s No					



Have you ever had:			
Check all that apply.			
Arthritis	Seizures	Abnormal bleeding	Recent weight loss
Arteriosclerosis	Fainting	Ulcers/colitis	Rheumatism
Birth defects	Hearing disorders	Difficulty breathing	Scarlet fever
Cancer	High or low blood sugar	Hospitalized for any reason	Sexually transmitted disease
Emotional problems	Hypotension (low	Emphysema	Sickle cell anemia
Head or face injury Heart murmur/trouble	blood pressure)	Glaucoma	Sinus trouble
	Nervous disorder	Thyroid disease	Tattoos/body piercing
History of substance abuse/drug addiction	Rheumatic fever	Angina	TMD/TMJ (jaw pain)
Kidney problems	Heart attack/stroke	Artificial hip/joints	X-ray or cobalt
Numbness of arms or	Heart surgery	Gout	treatment
hands	Pacemaker	Chest pain	Yellow jaundice
Swollen, still painful	Artificial valves	Circulatory problems	Chronic fatigue
joints	Congenital heart	Cold sores	syndrome
Allergies	defect	Congenital heart	Cough-persistent or
Asthma	Mitral valve prolapse	lesion	bloody
Blood disease	Artificial bones/joints	Cortisone medicine	Latex sensitivity
Diabetes	Shingles	Convulsions	Smoker
Endocrine problems	HIV/AIDS	Herpes	Swelling of feet/ankles
Intestinal disorders	Blood transfusions	Leukemia	Swollen neck glands
Hepatitis A, B, or C	Fever blisters	Excessive thirst	Tonsillitis
Hypertension (high	Sinus problems	Hay fever	Tumor or growth on
blood pressure)	Severe/frequent	Heart disease	head/neck
Liver problems	headaches	Hives/skin rash	Easily winded
Pneumonia	Cancer/chemotherapy	Hypoglycemia	Anaphylaxis
Shortness of breath	Radiation treatments	Irregular heartbeat	Alzheimer's disease
Anemia	Psychiatric problems	Lung disease	Frequent diarrhea
Bruise easily	Tuberculosis	Osteoporosis	Genital herpes
Dizziness	Venereal disease	Pain in jaw joints	Renal dialysis
Epilepsy	Hemophilia	Parathyroid disease	Spina bifida

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.			
Acrylic	Dental anesthetics	Nitrous oxide	Tetracycline
Aspirin	Erythromycin	Novocaine	Valium
Barbiturates (sleeping	lodine	Penicillin/antibiotics	Xylocaine
pills)	Latex rubber	Sedatives	
Codeine	Metals	Sulfa drugs	





uragar.co						
Are you being/have you ever been treated for cancer of any kind? If yes, please explain:						
Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate						
(Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia),						
risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). Yes No						
Do you take or have you taken Phen-Fen or Redux? Yes No						
Do you smoke or chew tobacco? Yes No						
Do you use alcohol, cocaine, or other drugs? Yes No Do you wear contact lenses? Yes No						
Do you wear contact lenses? Yes No Are you on a special diet? Yes No						
Have you lost or gained more than 10 pounds in the past year? Yes No						
Do you use more than two pillows to sleep? Yes No						
Have you ever had any excessive bleeding requiring special treatment? Yes No						
When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness						
of breath, or feeling tired? Yes No						
Have you been treated in a hospital in the last five years? Yes No						
If female, please mark if you are:						
Pregnant - If so, please enter your due date or week #:						
Trying to get pregnant Nursing On birth control						
Please list all current prescriptions:						
Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly						
affect your dental treatment:						
Do you wish to talk to the dentist privately about any problems/concerns? Yes No						
All of the above information is correct to the best of my knowledge. I understand that providing incorrect						
information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of						
any changes in medical status. I understand that the above information is necessary to provide me with						
dental care in an efficient and safe manner. Should further information be needed, you have my permission						
to ask the respective health care provider or agency, who may release information to you.						
Signature (Type your name to sign electronically, or print and sign): Date (mm/dd/yyyy): ///						
For office use: Reviewed by: Title: Date: / /						
Reviewed by: Title: Date: / /						





Our Office				
What do you already know abou	t our office and what are your e	xpectations?		
What would it take for you to true	st us to be your dentist?			
We can look at your mouth from	3 different perspectives. This w	vill help us determi	ne how to best treat you and your sp	ecific
dental needs. What combination	of these would you like us to u	se for your situation	n?	
As a general dentist	As a cosmetic dentist	As a functiona	al (bite, TMJ) dentist	
At what point do you want us to	nitiate treatment for you?			
When something isn't ide	eal When something w	vorsens W	hen my tooth hurts or breaks	



HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting
 quality assessment and improvement activities, auditing functions, cost-management analysis, and
 customer service. An example would be an internal quality assessment review. We may also create
 and distribute de-identified health information by removing all references to individually identifiable
 information.
- To Your Family and Friends: 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. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders



of courts or administrative agencies

- Disclosures for law enforcement purposes, such as to provide information about someone who is or
 is suspected to be a victim of a crime; to provide information about a crime at our office; or to report
 a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

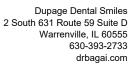
- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 25, 2014, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S.





Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights 200 Independence Avenue, S.W. Washington D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-6775

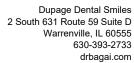
HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Mount Prospect Smiles to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

alcolocato triat cocarroa pi	ior to the date riovelte ti	no concont will not be and	iotoa.
Signature (Type your name to s	ign electronically, or print and	sign):	Date (mm/dd/yyyy): / /
If signing on behalf of someone,	explain your relationship to the	ne patient:	
For Office Use Only			
Patient refused or was unable to	o sign. Good faith effort was n	nade to obtain acknowledgeme	ent of receipt.
The following circumstances pro	phibited the patient from signir	g the consent form:	
Describe your good faith effort to	o obtain the individual's signa	ure on this form:	
Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date: / /





Oral Cancer Screening Form

Our dental practice continually looks for advances to ensure that we are providing the optimum level of oral healthcare 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 of increasing incidence and mortality rates of oral cancer. 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. Studies also suggest that human papillomavirus (HPV 16/18) plays a role in more than 20% of oral cancer cases. Oral cancer risk by patient profile is as follows:

- INCREASED RISK: Patients age 18-39, sexually active patients (HPV 16/18)
- HIGH RISK: Patients age 40 and older, tobacco users (ages 18-39, any type within 10 years)

 HIGHEST RISK: Patients age 40 and older with lifestyle risk factors previous history of oral cancer 	s (tobacco and/or alcohol use);
Please select one:	
YES - I would like to have the oral cancer exam.	
NO - I would prefer not to have the oral cancer exam at this time.	
Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):
	/ /