PATIENT REGISTRATION AND MEDICAL HISTORY

Date_____ (PLEASE PRINT)

Patient _____
Last Name First Name Initial Preferred Name

Street Address_____ City_____ State_____ Zip_____

Home Phone (____)_____ Alt. Phone (____)_____ Email address:_____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed by _____ Occupation_____

Employer Address _____ Work Phone (____)_____

Spouse/Parent Name _____ Spouse/Parent Birthdate _____

Employed by _____ Occupation_____

Employer Address _____ Work Phone (____)_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security # _____ Spouse/Parent Social Security #_____

Name of Dental Insurance Company _____ Group Number_____

In case of emergency, who should be notified?_____ Phone (____)_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Problems
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves or Joints
- ☐ Recent Weight Loss
- ☐ Back Problems
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Chronic Diarrhea
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Special Diet
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ HIV / AIDS or Other Immunosuppressive Disorders
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, please describe _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever responded adversely to medical or dental treatment?_____

Are you taking any medication at this time?_____ If so, what_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history?_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date_____ Signature_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date *Signature*

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request
Name of Minor/Child

and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date *Signature of Insured/Guardian*

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

_____ _____
Date *Signature of Insured/Guardian*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

MEDICAL HISTORY UPDATE

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

_____ _____
Date *Patient Signature*

_____ _____
Date *Dentist Signature*

Nuance Dental Studio
30 East 60th Street, Suite 603
New York, NY 10022
(212)758-2185

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

I, _____, have reviewed a copy of this office's Notice of Privacy.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**

_____
_____
_____

Nuance Dental Studio
30 East 60th Street, Suite 603
New York, NY 10022
212.758.2185

PATIENT CONFIDENTIALITY

In this office, **Patient Confidentiality** is a prime concern. Please indicate below with whom our office can or cannot leave a message. Please check where appropriate.

	YES	NO	DOESN'T APPLY
Spouse	___	___	___
Children	___	___	___
Answering Machine Home	___	___	___
Answering Machine Work	___	___	___

Are you able to receive calls at your workplace? _____

May we call you at your workplace and state who is calling? _____

Due to our confidentiality regulations, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.

Please check with whom we may discuss your situation.

	YES	NO	DOESN'T APPLY
Spouse	___	___	___
Children	___	___	___

Children and/or Significant Others

Name _____
Relationship _____
Phone _____

Name _____
Relationship _____
Phone _____

_____ _____
Signature Date

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30 East 60th Street, Suite 603
New York, NY 10022
212.758.2185

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Automatic monthly billing to your Visa or MasterCard

___ Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.
Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.
If none of the above apply, please see the office manager. Thank you.

_____

Print your name here and sign below

***x*_____**

***Date:*_____**

To Our Valued Patient,

Thank you for choosing Nuance Dental Studio as your dental provider. We have a personal, professional and ethical responsibility to care for you health to the best of our abilities. Missed appointment and failure to comply with recommended treatment schedules and/or procedures prevent us from achieving our goal of optimum health for recommendations; we will not be able to continue treating you in good conscience. Therefore, the following policies must be agreed upon:

1. No-shows are not acceptable. Failure to make it to an appointment not only compromises your health but also inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot keep an appointment, you are expected to call **48 hours** before your appointment to reschedule. There is a $150.00 broken appointment fee that is not covered by your insurance.
2. Timeliness is required. We will see you on time and get you out on time, unless there is an emergency. We request that you be on time for your visits.
3. If you miss an appointment you must make it up. It is critical to your health to do so to avoid set backs in the care and maintenance of your teeth and gums.
4. Insurance: Treatment recommendations are based on health, not on your insurance or lack thereof. If you have insurance it is your responsibility to be aware of what your benefits are. Remember insurance companies are not concerned about your health or well being, we are. We will provide you with an estimate of benefits; however, you are fully responsible for your treatment. Your benefits are a contract between you and your insurance company. We are not responsible for what your insurance will or will not cover.
5. We run a **ZERO** balance office; therefore all financial aspects of your treatment will be discussed prior to the beginning of treatment. Any and all co-pays and/or deductibles must be made at the time treatment is rendered. All patients are expected to comply with their financial agreements with this office. Any insurance balance not received after 90 days will become your responsibility.

We greatly appreciate your cooperation, and keep in mind that any miscommunication you should encounter, please make us aware immediately, so we may give it the proper attention for an effective resolution.

Nuance Dental Studio

_____

Patient

Oral 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 that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use arc 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 lifstyle risk factors (tobacco and/or alcohol use); previous history, of oral cancer*

We have recently incorporated OralCDx Brush Test into our oral screening standard of care. We find that using OralCDx Brush Test along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. OralCDx Brush Test is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. OralCDx Brush Test 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 tile potentially disfiguring effects of oral cancer and possibly save your life. The OralCDx Brush Test 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 might not he covered by your insurance. The fee for this enhanced examination is **$200.00**.

Yes. I authorize the clinician to perform the OralCDx Brush Test 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 OralCDx Brush Test exam at this time.

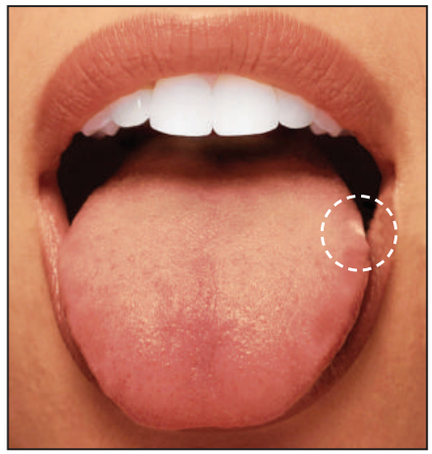
Print name: _____

Signature: _____ Date: _____

Finding spots and testing them is the key to preventing oral cancer

We perform a painless BrushTest® of common oral spots to help detect unhealthy cells while they are still harmless.

Your doctor can help prevent oral cancer before it ever starts



What You Should Know:

1. **ORAL SPOTS ARE COMMON**
   Most people will have tiny white or red spots in their mouth at one time or another.

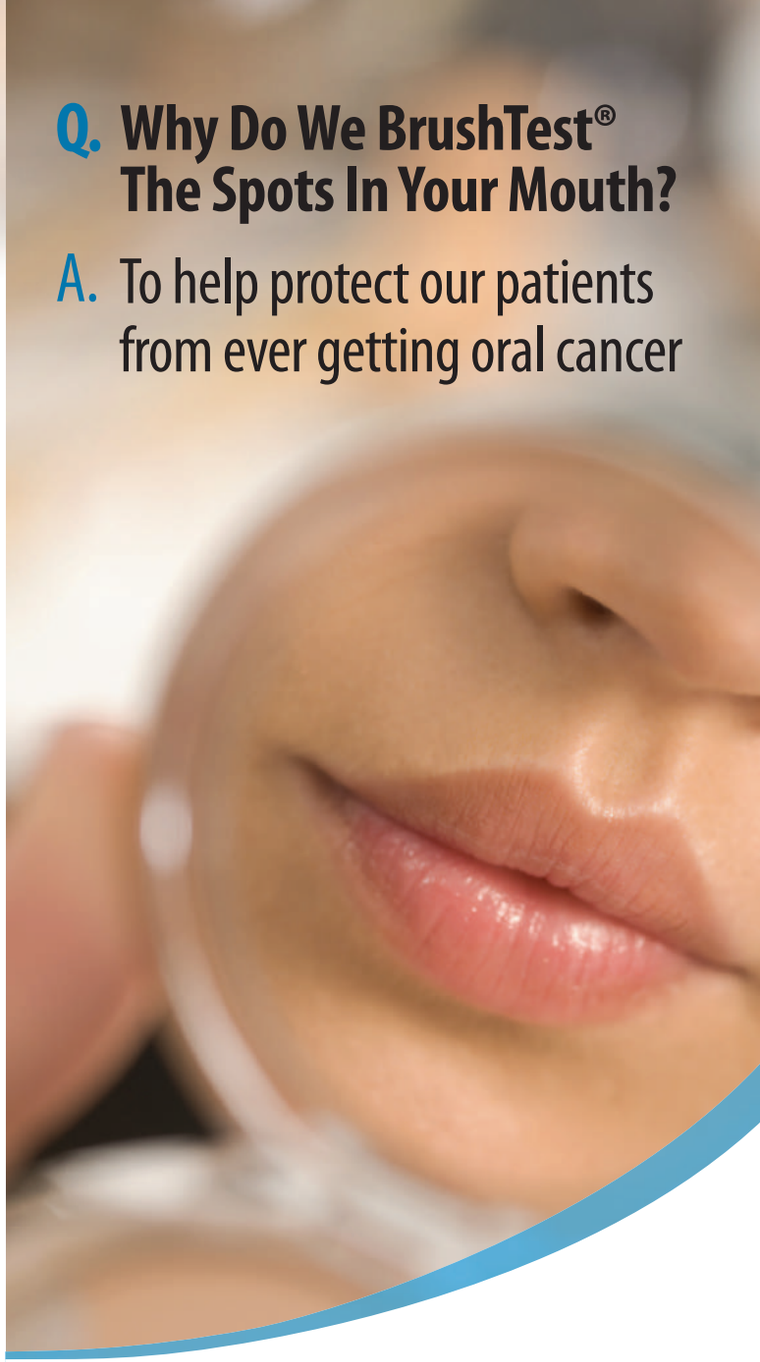
2. **ORAL SPOTS SHOULD BE TESTED**
   Although the vast majority of these spots do not contain unhealthy cells, your doctor may perform the BrushTest® to rule out abnormality.

3. **MOST ORAL CANCER IS PREVENTABLE**
   If abnormal cells are identified, they can then typically be removed - years before they can harm you.

OM_0142C 11/25/15

Q. Why Do We BrushTest® The Spots In Your Mouth?

A. To help protect our patients from ever getting oral cancer



OralCDx® The BrushTest®

Oral Cancer

Rising in women, young-people and non-smokers

- Oral cancer kills about as many Americans as melanoma and twice as many as cervical cancer.
- Oral Cancer is rising in women, young people and non-smokers.
- Over 25% of oral cancer victims have no known risk factors.

Almost every oral cancer starts as a small red or white precancerous spot, which can be seen during a careful oral examination. These spots may contain unhealthy (dysplastic) cells but are still harmless today and can typically be removed before they can progress to cancer.

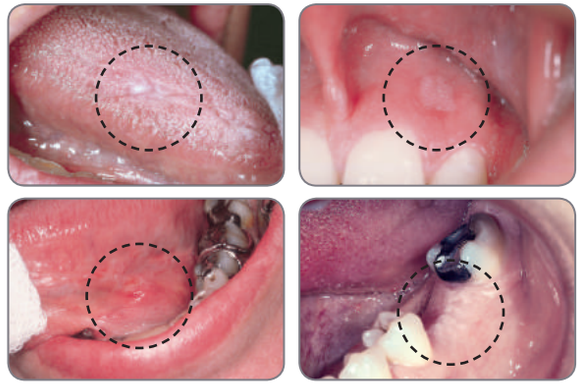
The Good News

We can now help protect you from oral cancer

As part of your routine exam, all areas of your mouth will be checked for any changes, including:

- **Cheeks**
- **Gums**
- **All surfaces of your tongue**
- **Area underneath your tongue**

We will look for small red and white spots which appear like these:



Most people will have a spot in their mouth at one time or another. Although the majority are caused by everyday trauma such as cheek biting or pizza burns, some contain unhealthy cells that if left alone could become a problem.

Your doctor has a painless test to sample these spots to help find unhealthy cells before they can harm you.

Oral Cancer is Preventable

How oral cancer can be stopped before it can even start:

1. **Find any spot(s).** Most people have a small white or red spot in their mouth at one time or another. These spots can be found during your oral examination, so be sure to routinely visit your doctor.
2. **Test them to rule out precancer.** Although most of these spots do not contain unhealthy cells, a painless BrushTest of your spot can help rule out this possibility.
3. **Remove any precancerous spot(s).** If precancerous cells are found by the laboratory, the spot can typically be removed long before it can become cancerous.

If you have any questions about how the BrushTest® works, feel free to call OralCDx at 877.71.BRUSH (877.712.7874).

OralCDx®
The BrushTest®

www.brushtest.com