MODERN DENTAL SMILES

COSMETIC • FAMILY • IMPLANT

Date _____

Patient's Name: _____ **Date of Birth**: _____

Parent or Guardian Name: _____**Date of Birth**: _____
(If patient is not of age)

Social Security Number: _____**Driver's License Number**:_____

Address: _____ **Apartment Number**: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone Number: _____ **Work Phone Number**: _____

Cell Phone Number: _____ **E-Mail Address**: _____

Spouse's Name: _____**Date of Birth**: _____

Social Security Number: _____ **Work Phone Number**: _____

Emergency Contact: _____**Phone Number**: _____
Last First

Dental Insurance

Company: _____ **Group Number**: _____

Policy Holder's Name: _____ **Social Security Number**: _____

Employment

Occupation: _____ **Spouse Occupation**: _____

Company Name: _____ **Company Name**: _____

Address: _____ **Address**: _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that information is true and correct of my knowledge. I will notify you of any changes in my status or the above information.

Signature:_____ **Date:** _____

Patient Information

It is important that we know about your medical and dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire…

Dental History

Patient Name: _____

How LONG SINCE you have seen a Dentist _____

Last COMPLETE Dental Exam, Date: _____

Last FULL MOUTH X-RAYS, Date: _____

Are you having PROBLEMS now? YES NO

Please explain _____

Is your present dental health POOR? YES NO

Do you have any frequent headaches? YES NO

Are your teeth sensitive to HOT, COLD, SWEETS, or PRESSURE? YES NO

Do your gums BLEED, or feel TENDER or IRRITATED? YES NO

What would you like to change MOST in the appearance of your teeth? _____

Do you use dental floss or toothpicks? YES NO

Do you have any swelling, sores, or blisters in your mouth? YES NO

Do you feel you have unpleasant breath at times? YES NO

Do you smoke or chew tobacco? YES NO

Are you aware of the new techniques in dentistry? YES NO

Are you UNHAPPY with the APPEARANCE of your teeth? COLOR SHAPE

How do you feel about your teeth? GOOD NORMAL BAD

Please explain_____

Do you have LOOSE, TIPPED, SHIFTING teeth? YES NO

Are your teeth all in alignment (straight)? YES NO

Do you have any MISSING or CHIPPED teeth? YES NO

Do you have any old fillings or dental work that you do not like? YES NO

Are you nervous about dental treatment? YES NO

What type of toothbrush do you use? SOFT MEDIUM HARD

Is there anything about your mouth that CONCERNS you? _____

_____

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment…

FEAR of pain _____ # LACK of concern _____ #
COST of treatment _____ # MISSING work/school time _____ #

Medical History

Primary Physicians Name (MEDICAL): _____ **Date of last physical exam**: _____

Do you have, or have you had any of the following? (*Please indicate if NOTHING applies with a 'N/A'*).

☐ Any heart problems	☐ HIV- Positive	☐ Diabetes	☐ Pacemaker
☐ High blood pressure	☐ Allergies to anesthetics	☐ Hepatitis Type:_____	☐ Sinus Problems
☐ Low blood pressure	☐ Allergies to:	☐ Herpes	☐ Stroke
☐ Circulatory problems	_____	☐ Measles	☐ Typhoid fever
☐ Nervous problems	_____	☐ Mumps	☐ Tonsillitis
☐ Radiation treatments	☐ Anemia	☐ Psychiatric care	☐ Tuberculosis
☐ Excessive bleeding	☐ Asthma	☐ Rheumatic Fever	☐ Ulcer
☐ AIDS	☐ Thyroid Issues	☐ Malignancies	☐ Venereal Disease

Are you or do you think you may be pregnant? YES NO Due Date:_____ Blood pressure: S _____/D_____/_____

Please describe any medical treatment, impending operations or other medical or dental information that may possibly affect your dental treatment:

_____

Please list any other known DRUG ALLERGIES: _____

Please list any CURRENT MEDICATIONS: _____

_____

Have you ever been told to Pre-Medicate (take antibiotics) BEFORE dental work? YES NO Comments: _____

Signature: _____ **Date: _____**

Patient Information

The ViziLite Plus® Test

The test that is clinically proven to detect oral cancer 100% of the time

The Oral Cancer Problems Facing Our Society Today:

- Oral Cancer is the 6th most common cancer in the United States.
- 30% of the people that get oral cancer have no risk factors for it.
- One American dies every hour from oral cancer.
- Oral Cancer commonly causes facial disfigurement, loss of quality of life, or death.
- All oral cancers start out as invisible to the naked eye.
- The doctor and his staff cannot see oral cancer with normal examinations until it reaches stage 3 or 4.
- Often times there are no signs or symptoms with stage 1 or 2 cancer.
- After treatment of stage 3 or stage 4 Cancer, only 50% of patients live beyond 5 years.
- The only 100% way to ensure that we're detecting stage 1 or 2 oral cancer is to use a proven test like the ViziLitePlus Test.

We offer break-through technology that detects Oral Cancer in its earliest stages and offers piece of mind for patient concerned about oral cancer:

- The ViziLite Plus test is a simple and painless examination that will illuminate stage 1 and 2 oral cancers before they become visible to the naked eye.
- The ViziLite Plus test is a proven detection procedure comparable to a mammography, pap-smear, or PSA.
- Early detection of oral cancer can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life.

The Cost:

- The test is not covered by insurance and normally costs $159.00.
- Our office discounts the fee to **$81.00** to make it more affordable and more accessible to our patients.
- It could save your life, which we see as priceless.

How it works:

- If the test shows a glowing area when it is first administered, the glowing area could be one of three things:
  - Trauma
  - Benign abnormalities in the oral tissue
  - Malignant abnormalities in the oral tissue (cancer)
- If there is a glowing area when the test is first administered the doctor will run a second test for no additional charge that will determine if the glowing area is actually trauma, benign, or malignant. At this time the doctor may recommend that you see a cancer specialist.

- It is important to note that benign changes in the oral tissue can turn malignant in the future. For this reason, the doctor recommends a yearly follow-up ViziLitePlus Test. Most patients schedule this around their birthday to make sure they remember. Please make sure you schedule an appointment to follow-up on benign spots because they can turn into malignancies with time.

Would you like to have the ViziLitePlus Test done today? (Please check one)

☐ **Yes.** I would like to have the ViziLite Plus test for the additional cost of **$81.00** today.
☐ **No.** I would prefer not to have the ViziLite Plus test at this time.

I UNDERSTAND THAT SIGNING THIS FORM DOES NOT OBLIGATE ME TO TREATMENT.

Print Name:_____

Signature:_____ Date:_____

Patient Information

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4050 S. US HIGHWAY 1, STE 322
JUPITER, FLORIDA 33477
(561)691-6055

2280 N. CONGRESS AVENUE
BOYNTON BEACH, FL 33426
(561)732-2400

13860 WELLINGTON TRACE, #14
WELLINGTON, FLORIDA 33414
(561)791-4440

Appointment Confirmation Policy

At Modern Dental Smiles, we understand that our patients are often busy, so we offer different ways to confirm your appointments to meet those standards. You have to ability to confirm by simply replying "C" to a text message or clicking "Confirm Appointment" on the email sent on our behalf. If you receive a voicemail, we ask that our patients call back even after hours and leave us a detailed message and one of our friendly staff members will confirm your appointment for you the next day.

If we have not heard or received a confirmation after **three attempts have been made, your appointment will be rescheduled and offered to another patient in need.**

We thank you in advance for helping us serve your dental needs more efficiently by keeping your scheduled appointment.

Modern Dental Smiles

_____ _____

Signature of patient, parent, guardian or personal representative **Date**

Patient Information

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PATIENT AUTHORIZATION

I hereby authorize payment directly to Modern Dental Smiles PA, Modern Dental Smiles of Wellington PA, and Kurt O Bally DMD PA, of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Modern Dental Smiles PA, Modern Dental Smiles of Wellington PA, and Kurt O Bally DMD PA, to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals by any method, including electronic transfer. I authorize the use of this signature on all insurance submission. I understand that all testimonials and records concerning my treatment given by video, photograph, verbal, written, or web communications are property of Modern Dental Smiles PA, Modern Dental Smiles of Wellington PA, and Kurt O Bally DMD PA and may be used for advertising and promotion of the corporation or for teaching purposes within accordance of HIPPA law. I authorize photos, x-rays, or other records of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. My identity will not be reveal to the general public however, without my permission.

_____ _____

Signature of patient, parent, guardian or personal representative **Date**

DENTAL BENEFIT EXPLANATION & AGREEMENT

It is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs, and we assume that you are concerned as we are about maintaining your good health. Generally, dental benefits pay a percentage of each procedure up to a set yearly maximum. The benefits available to you are established by the plan package your employer purchased.

As a courtesy to you, we will submit claims to your dental plan carrier. We also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion at the time services are provided.
****However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We take no responsibility for any denials by dental plans****

I agree to these policies regarding my dental benefits and will be held responsible for the entire balance for services rendered after 45 days of service if my dental insurance has not paid your office directly.

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services or items provided to me, to my minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor child, or to the patient for whom I have legal responsibility.

_____ _____

Signature of patient, parent, guardian or personal representative **Date**

Patient Information