

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street _____ City _____ State _____ Zip Code _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID/Social Security # _____ Group #: _____

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID/SS #: _____ Group #: _____

Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____

Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

The undersigned hereby authorize Dr Richardson or Dr Monroe to take X-rays, study models, photographs, or other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize Dr Richardson or Dr Monroe to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (name of the patient) _____.

I have read the above conditions and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

Important dental insurance information for our patient

We know understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage, which fits the company budget. Each plan is slightly different in its covered services. **We encourage you to become familiar with your policy exclusions, deductibles, maximum, anniversary date and required co-payments.** **There are thousands of dental plans & we are not responsible for knowing the details of your particular plan.**

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Re-filing your insurance a second time within 60 days if still unanswered.
3. Following the American Dental Association guidelines for coding procedures and filing insurance.
4. Providing you're insurance company with necessary x-rays, narratives and any other pertinent information for their decision making process.

Our expectations of you as the owner of the policy:

1. Payment of fees not covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Realizing the dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on your employers' plan and on the premium paid for insurance and not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within **75** days of your outstanding balance.
5. Keeping our office informed of your anniversary date and any changes in your insurance coverage or employment.

Thank you for your cooperation with your dental insurance coverage. Please sign the space below and have your insurance card ready for us to copy for our file.

I hereby authorize Dr. Rob Richardson and Dr. Leslie Monroe to release to my insurance company, information acquired in the course of my dental care. I hereby authorized benefits to be paid directly to said doctors. I understand I am responsible for any unpaid balance.

Signature of Patient/Insured

Date

Other Information

Date _____

What is your main concern? _____

Date of last dental cleaning _____

Date of last dental visit _____

Do you have any dental problems now? _____

Do you have any teeth that are sensitive to hot, cold, & sweets? _____

Have you ever had orthodontic treatment? _____

Have you ever had your wisdom teeth removed or any other oral surgery?

Have you ever had any periodontal (gum disease) treatment? _____

Have you ever had your teeth ground or your bite adjusted? _____

Have you ever worn a bite plate or other appliance? _____

Have you ever noticed any loosening of your teeth? _____

Does food tend to become caught in between any of your teeth? _____

Do you suffer from pain and/or swelling of your gums? _____

Do your gums bleed when you brush your teeth? _____

How often do you floss? _____

Have your parents ever experienced any gum disease? _____

Have you ever been concerned about your breath? _____

What products do you use to help freshen your breath? _____

Do you use any tobacco products? _____

Have you ever experienced any clicking of your jaw? _____

Have you experienced any pain in your jaw joint, ear, or side of your face? _____

Have you experienced any discomfort in opening or closing your jaws? _____

Have you experienced any difficulty chewing? _____

Do you clench or grind your teeth while awake or at night? _____

Do you bite your lips or cheeks regularly? _____

Do you hold foreign objects with your teeth (pens, pencils, pipes, or bite fishing line, etc)? _____

Do you mouth breathe while awake or asleep? _____

Do you snore on a regular basis? _____

Do you play any contact sports? _____

Do you feel nervous about having dental treatment? _____

Do you expect to eventually lose all of your teeth? _____

What bothers you about dental treatment (fear of needles, fear of feeling something, etc)?

Are you dissatisfied with the appearance of your teeth? _____

What would you like to change? _____

List any non medication allergies you may have (metals, latex, etc) _____

Reason for leaving other dentist: _____

Richardson & Monroe, DDS, PA
**CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION**

SECTION A: PATIENT GIVING CONSENT

Name: _____ Telephone: _____ SS# _____
Address: _____ Email: _____

**SECTION B:
TO THE PATIENT---PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health and insurance information to carry out treatment, payment activities, and healthcare operations.

Notice to Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we may have.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sara Burrow, Financial Coordinator
Telephone: (501) 224-0144 Fax: (501) 224-0355
Email: front4@radiantsmile.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continuing treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health and insurance information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Revocation of Consent:

I revoke my Consent for your use and disclosure of my protected health and insurance information for treatment, payment activities, and healthcare operations.

I understand that the revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Include a completed Consent in the patient's hard chart



- Oral cancer kills one person every hour, 24 hours a day in North America.
- The overall 5 year survival rate for oral cancer is 52%, but when **discovered early, it increases to 80-90%.**

As Healthcare providers, we continually review new medical technologies looking for those procedures that represent the latest advances in medical care for our patients. We have recently evaluated a new device and found that using it in conjunction with a conventional visual oral examination enhances our ability to identify, evaluate and monitor oral mucosal abnormalities. (In plain English, we have the latest technology to help identify tissues which can be precursors to oral cancer and we can find it earlier than we see it with the naked eye.)

This painless, non-invasive test gives us a better chance to find any oral abnormalities you may have, at the earliest possible stage. This technology has successfully improves the identification of pre-cancerous abnormalities in thousands of exams of squamous epithelium of the cervix and has recently been cleared by the FDA for oral application, early detection of such abnormalities can result in the early treatment for pre-cancerous tissue. (Plain English.....this technique has been used for many years to help detect early tissue changes in the cervix of thousands of women, and it has worked very well saving many lives.)

This new device is called the Velscope and we are now offering it to all of our patients. This exam is not a new procedure and insurance companies are now covering some of the procedure cost in a few cases however we will not be able to confirm your benefits. **There is a fee of \$35 for using this device to aid in the examination of your oral tissue.**

For our records, please indicate below whether or not you wish to have the Velscope exam:

Yes, please. I authorize my clinician to use the Velscope along with my conventional visual oral exam. I accept financial responsibility for this enhanced visual exam if the procedure is not covered under my insurance.

Print Name: _____

Signature: _____ Date: _____

No, thank you. I would prefer not to have the Velscope exam.

Print Name: _____

Signature: _____ Date: _____



We are delighted to welcome you to our practice and are pleased that you have selected our office to serve your dental needs. We are serious about providing superior dental care, and proud of our dedication to our patients. Our goal is to help you feel and look your best.

In order to provide you with excellent service, please complete the enclosed forms and return them when you come for your appointment. Your reserved time for your first appointment is approximately 70 minutes. At this first visit, we will be taking a full set of dental x-rays and photos. We will also be doing a full exam, including an oral cancer screening. We will be able to diagnose the best preventative care for you (general teeth cleaning or gum treatment). We will then schedule time with one of our hygienists and all other necessary appointments. Arriving on time with your paperwork completed, will allow us to complete your exam and give you the best possible care. We look forward to meeting you. Please feel free to call if you have any questions.

Sincerely,

Leslie Monroe, DDS

Rob Richardson, DDS