Smiles 4 FAIRFAX

Howard T. Ngo, DDS, FAGD

Family and Comprehensive Dentistry

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 incident 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 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 ages 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 (tobacco and/or alcohol use); previous history of oral cancer*

We have recently incorporated Vizilite Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life.

The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431**: however this exam is currently not being covered by most dental carriers, therefore you are responsible for the fee of $92.00**

☐ **Yes,** I would like to have the ViziLite Plus exam and I agree to pay the fee today.

☐ **No,** I would prefer not to have the ViziLite Plus exam at this time.

Print Name: _____

Signature: _____ Date: _____

The key to reducing the devastating impact of oral cancer is early detection.

Howard T. Ngo, DDS, FAGD

PATIENT REGISTRATION

Patient Name _____ **Male** **Female** **Date of Birth** _____

SS# _____ **Child** **Single** **Married** **Other**

Street Address _____ **Email** _____

City _____ **State** _____ **Zip Code** _____

Home _____ **Work** _____ **Cell** _____

If a child; parent or guardian name _____

Employer _____ **Position** _____

Business Address _____

Spouse/ Partner _____ **Date of Birth** _____ **SS#** _____

Spouse/ Partner Employed by _____ **Work Phone** _____

Person responsible for account _____ **Dental Insurance Company** _____

Name of Insured _____ **Insured SS#** _____ **Date of Birth** _____

Group Policy # _____ **ID#** _____

Who may we thank for referring you? _____

If child please list who is allowed to bring child to receive/ authorize treatment other than listed guardians above:

_____

Assignment and Release

I authorize Smiles 4 Fairfax, PLC to file claims for services rendered to me by providers of Smiles 4 Fairfax PLC. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family by the office of Dr. Howard T. Ngo, DDS, Smiles 4 Fairfax PLC. I authorize Dr. Howard T. Ngo, DDS and Smiles 4 Fairfax PLC to release any information, including medical information for this or any related claims to any insurance company or reimbursing agency in order to determine benefits which I am entitled. I also understand that Smiles 4 Fairfax has no control over the insurance company or any benefit decisions made once claims are received. I understand that the coverage agreement is determined between my employer and the insurance company only.

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Howard T. Ngo, DDS. I clearly understand that it is my responsibility to make sure the account is paid in full. All co-pays and deductibles are to be paid at the time services are rendered, if for any reason any expected portion of my bill is not paid by my insurance company I am responsible for the balance due within 30 days and that any balances past 30 days would be subject to late and financing fees.

_____ _____

Signature of Patient/ Parent/ Guardian Date

_____

Print name of Patient/ Parent/ Guardian

Health History

Are you currently under a physician's care? Yes No Details: _____

Physician's Name_____Phone_____

Physician's Address_____

Are you allergic to or have you had a reaction to:

Local anesthetics	Yes	No	Penicillin/ Antibiotics	Yes	No
Sulfa Drugs	Yes	No	Barbiturates/ Sedative/ Sleeping Pills	Yes	No
Aspirin	Yes	No	Iodine	Yes	No
Codeine or Other	Yes	No	Narcotics	Yes	No
Latex	Yes	No	Other	Yes	No

If yes or other please list & describe type of reaction:

Medication _____ Reaction_____

Do you have any past history of surgeries? Yes No Please list type of surgery, complications if any, and date performed:

_____

Are you currently or have you been on:

Fosamax (Alendronate)	Yes	No	Denosumab (Prolia)	Yes	No
Fosamax Plus D	Yes	No	Zometa (Zoledronate)	Yes	No
Actonel (Residronate)	Yes	No	Aredia (Pamidronate)	Yes	No
Boniva (Ibandronate)	Yes	No	Other	Yes	No

If yes: Duration of therapy: _____ Dose of Medication: _____
If you are no longer on the medication, years since discontinuation: _____

Have you had:

Any kind of cancer? Yes No

If yes:

What is the type of cancer you have had? _____
Have you been treated with chemotherapy? _____
What type of chemotherapy have you had? _____

List All Current Medications (Prescription, Over-the-Counter, Herbal Supplements)

	Medication	Dosage	Frequency
1			
2			
3			

Past & Current Medical Conditions (Please mark all that apply)

__Heart Disease
__Heart Failure/Attack
__Rheumatic Fever
__Heart Murmur
__Mitral Valve Prolapse
__Heart Surgery
__Congenital Heart Problem
__Artificial Heart Valve/Stent
__Pacemaker
__Implanted Defibrillator
__High Blood Pressure
__Stroke
__Diabetes
__A1C Level
__Family History of Diabetes
__Artificial Joints
__Organ Transplant
__High Cholesterol
__Bleeding Problem
__Hemophilia
__Blood Transfusion
__ Anemia
__Leukemia
__Fainting/dizzy spells
__Nervousness
__Lung Disease
__Asthma
__Emphysema
__Sleep Apnea
__Tuberculosis
__Cancer
__Radiation Therapy
__Chemotherapy
__Kidney Disease
__Eating Disorder
__Acid Reflux/GERD
__Stomach Ulcer
__Liver Disease
__Hepatitis A, B, C
__HIV Positive
__Autoimmune Disease (AIDS)
__Thyroid Disease
__Glaucoma
__ Sjorens Syndrome
__Fibromyalgia
__Arthritis
__Depression
__Psychiatric Disorder
__Epilepsy
__Cerebral Palsy
__Venereal Disease

If you have answered yes to any of the above please explain: _____

Do you have any disease, condition, or problem not listed that you think I should know about? Yes No
Explanation: _____

Women:
Pregnant Yes No If yes, what trimester? _____
Nursing Yes No Using Oral Contraceptive Yes No If yes, what? _____

SIGNATURE_____DATE_____

DENTAL HEALTH QUESTIONAIRE

Your initial clinical exams combined with your dental and medical history are important for us to recommend the best overall treatment approach for you. Oral health is directly related to your overall health and specific medical conditions are related to your mouth.

Please mention everything about your health.

What is the reason for your dental visit today? _____
How did you hear about our practice? _____
On a scale from 1-10 with 10 being the highest, how important are your teeth? _____
When was your last dental visit? _____ Last dental cleaning? _____
How frequently did you have your dental cleaning? _____
Who was your previous dentist? _____ Phone: _____
Were you told you have gum disease? _____ Were you treated? _____
Have you ever had orthodontic treatment? _____ Do you wear orthodontic retainers? _____
Name of Orthodontist: _____ Phone: _____
Have you had oral surgery? _____
Wisdom teeth removed? _____ When? _____
Have you had dental implants placed? _____ How long ago? _____
Do you or have you been told you grind/clench your teeth? _____
Do you have pain, popping or clicking in your jaws? _____
Do you wear or have an occlusal appliance? _____
Do your wear dentures or partial dentures? _____ How long? _____
Are any of your teeth sensitive to hot, colds or sweets? _____
Is your mouth frequently dry? _____ Are you noticing any swelling or lumps? _____
Do you have any loose teeth or trouble chewing? _____
Do you have any food that catches between your teeth? _____
Do you frequently get cold sores or oral blisters? _____
Do you notice bad breathe or tastes? _____ Do you gag easily? _____
Are you interested in whitening your teeth? _____ Enhancing your smile? _____
Are you interested in cosmetic dental treatment or dental veneers? _____
Have you ever experienced a complication following dental treatment? _____
Other Information you think we should know: _____

_____

_____ _____
Signature **Date**

Statement of Office Treatment, Informed Consent, and Acknowlegement of Financial Policy

Please feel confident that all information is kept confidential

Thank you for selecting us to help take care of your dental health. We are committed to having your treatment be a positive experience. It is our belief that all people who entrust their oral health to us want and deserve the finest dental care that we are capable of providing. Please understand your financial obligations are considered part of your treatment. Our purpose in providing you this financial information is to acquaint you with our policy for our mutual benefit. We will give you an estimate of costs required in advance of treatment so that you can come prepared for each visit. Please read the following and sign before being seen.

1. **Full payment is due at the time of service.** Other options include credit card (Visa/MasterCard/American Express or Discover) or third-party financing (with prior approval) through Care Credit – GE Money Bank.
2. **The following applies to those patients with insurance:**
   - If at your first appointment we are unable to verify your dental insurance or cannot obtain a list of benefits, full payment is due at the time services are rendered.
   - Patients are to pay their deductible and estimated co-payments at the time treatment is rendered.
   - While filing insurance claims is a service we extend to our patients, we must emphasize that as dental providers, our relationship is with our patients – not the insurance company. If a full payment is not received from your insurance carrier within 60 days, the balance becomes your responsibility and is subject to a finance charge and billing fee. To avoid these fees, please authorize us to transfer this balance to your credit card. We will mail you a transaction receipt once payment is processed. Amex/Discover/MC/Visa # _____ Expires _____
     Security Code _____ Signature _____
   - **Assignment of Benefits:** I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes the Practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.
3. **Minor Patients:** Must be accompanied by a parent or guardian for all appointments unless a written consent is provided. The adult accompanying the minor is responsible for payment.
4. **Past Due Account Fees:** There is a **$50** fee charged on all returned checks. Account balances older than 30 days are subject to a finance charge of 1.5% per month plus a monthly billing fee of $5.00. Any balance older than 90 days will be forwarded to "Collections" and subject to additional collection fees, including, but not limited to, attorney's fees, court costs, etc.
5. **Consent for Treatment:** I hereby give consent to the dentist and/or his/her designee(s) for the performance of any diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I further authorize the performance of all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me. I understand that no guarantee or assurances have been made as to the results that may be obtained.

Financial: The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check (once you are a patient of record), Visa, MasterCard, and American Express. To help you accept an extensive treatment plan we offer interest free financing with Care Credit (certain conditions are required as financing is through a third party and is subject to credit approval).

Financial Charges: All returned checks are subject to a **$50** fee. Once there is a returned check only certified funds will be accepted. Any balances over 30 days are subject to finance charges, late fees, certified mailing fees, and collections. We have the option to report your balance with us to any credit reporting agency and credit bureau. In the event that your account is turned over to a collection agency/ attorney, you are responsible for any attorney fees, court costs, etc.

Insurance: As a courtesy to all patients we will verify your dental benefits, but you are responsible to know your dental plan coverage, exclusions, and limitations. All estimates are subject to final review and approval by your dental insurance plan therefore the amount due is subject to change after final explanations of benefits (E.O.B.'s) have been paid. I understand that Smiles 4 Fairfax has no control or authority over my insurance company. That my dental insurance coverage is an agreement between my employer and my insurance company and that Dr. Howard Ngo has no control over the benefits.

Missed Appointment: All appointments require ***48 business hours*** notice for cancellations or reschedules or a fee of **$75 per hour** appointment length **per patient** will be charged. Appointments longer than 2.5 hours in length require 7 days' notice. We make every effort to remind patients by telephone prior to the appointment, **but please do not depend on this courtesy.** We have found that with the recent popular use of answering machines, pagers, and voicemails some of our patients are not receiving our reminders due to occasional malfunctions of these devices. **If we are unable to contact you directly; your appointment notice at the bottom of your walk out statement at your last appointment and any attempted phone calls will serve as confirmation of your appointment.** If you receive an e-mail you may confirm through e-mail services; but if you need to reschedule or cancel please do not depend on e-mail. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointment. If commitments for appointment are frequently broken, a non-refundable reservation fee equal to the appointment fee will be required prior to re-scheduling. Our ultimate goal is to help you achieve optimum dental health. Broken appointments only serve to delay your dental care and the opportunity to achieve that goal.

Radiographs (X-Rays), Intra-Oral Photos, and Records: It is our office policy that every new patient will have a Panoramic (Full head), Full Mouth Series, Bite-Wings (cavities), and oral photographs. We understand that insurance places limitations and exclusions on how frequently and how many we may take in a given time and/or visit. For the most comprehensive treatment we will waive any fee's not paid by insurance as long as you are a patient of the practice. Should records be requested we reserve the right to charge **$99** for any photography, radiographs, and record printing minus any outstanding charges.

Resin Based Composite Restoration (White/ Tooth Colored Fillings) and Porcelain/Ceramic Crowns: For the best of our patients, we recommended and *only place resin based composite* (white) restorations. Many dental insurance plans do not allow full benefits for composite (white fillings) and porcelain/ceramic performed on posterior (back) teeth. The plan benefits may pay for alternative (less expensive) treatment such as Amalgam (silver/mercury based restoration) or porcelain fused to metal crowns (crowns with a metal base structure)

Pulp Cap Treatment (medication): Many dental plans do not allow additional benefits for pulp cap treatment (this is a procedure which the filling is very deep and the nearly exposed pulp/ nerve is covered with a protective medication to help with healing and repair in order to minimize need for more invasive procedures). Patient is responsible for this payment at the time of treatment. If your insurance does not cover for this service or does not allow separate benefits, you will be charged a fee for the service.

I HAVE READ AND UNDERSTAND THE OFFICE INFORMED CONSENT, OFFICE POLICY, AND FINANCIAL POLICY. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FROM SERVICES RENDERED AND THAT CO-PAYMENT IS EXPECTED AT TIME SERVICES ARE RENDERED. I UNDERSTAND AND AGREE TO ALL POLICIES OF DR. HOWARD T. NGO, DDS AND SMILES 4 FAIRFAX, PLC.

Patient Name _____ _____
Date

Signature _____

If patient is a minor please print legal guardian name with signature instead

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protecting the privacy rights of every patient and the confidential information entrusted to us. The commitment of each employee to ensure that your dental health and health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy practices but will always inform you of any changes that might affect your rights.

PROTECTION OF YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you as allowed by the Health Insurance Portability and Accountability Act and the state of Virginia. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone – even family members- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment date, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose your information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We may use and/or disclose your health information to communicate reminders about your appointment including voicemail message, answering machines, and postcards.

PATIENT RIGHTS

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by the law. If you believe your rights have been violated, we urge you to notify us immediately.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that Smiles 4 Fairfax has provided me access to a copy of is HIPAA Privacy notice which explains how my health information will be handled in various situations. By law, we are required to have you sign this form on the first visit with Smiles 4 Fairfax. I been informed of my rights and to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and Omnibus Final Rule of 2013. I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services

Conduct normal health care operations such as quality assessment and improvement

Activities I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Please specify by circling the appropriate answer below if we may leave health related information (e.g., confirming appointments, lab/ radiology results, billing issues, or other doctor patient communications) with/on:

Home Answering Machine Yes _____ No

Work Voicemail Yes _____ No

Personal/ Work Email Yes _____ No

Cell Phone/ Text Messaging Yes _____ No

Relative or other person living with you: Yes _____ No

Who may we disclose personal information to? _____

Patient Name _____ _____

Date

Signature _____

Dependents also covered by this acknowledgement: _____

Howard T. Ngo, DDS, FAGD

RELEASE AND VIDEO/ PHOTO IMAGE PUBLICATION CONSENT VERIFICATION AGREEMENT

This Release and Video/ Photo Image Publication Consent Verification Agreement (AGREEMENT) is entered into between Smiles 4 Fairfax, Dr. Howard T. Ngo DDS (DENTIST) with its principle place of practice at 11351 Random Hills Rd Suite 290, Fairfax, VA 22030 and

_____ , (PATIENT).

RECITALS

This AGREEMENT is for the purpose of identifying any express or implied agreement, including, but not limited to, permission, consent, release, and/or authorization between DENTIST and PATIENT in connection with the medical services PATIENT received from DENTIST, and/or DENTIST'S associates.

DENTIST and PATIENT warrant and represent that PATIENT has given CONSENT and FULL AUTHORIZATION that any videos, photographs and/or images of PATIENT, under the following conditions:

1. The videos, photographs and/or images will be taken by DENTIST or by a photographer and/or skilled operator approved by DENTIST.

2. The videos, photographs and/or images may be used for:

    a. medical records, and if in the judgment of DENTIST, such videos, photographs and/or images and information relating to PATIENT may be published or republished, either separately or in connection with each other, in, but not limited to, building management, referrals; and/or court orders from law enforcement

    b. PATIENT further authorizes that the videos, photographs and/or images may be used by DENTIST or by any entity approved by DENTIST in treatment discussion with professionals that are approved by DENTIST.

3. At no time will PATIENT'S name, address, or any other alpha/numeric PATIENT-identifiable information be used in connection with photographs and/or images of PATIENT.

4. The videos, photographs and/or images may be modified and/or retouched in any way in DENTIST'S discretion.

By signing below, PATIENT certifies that he/she has read and understood each and every section of this agreement, and agrees to be bound by its terms.

_____ _____

Patient Signature Date