



**VIZILITE PRO 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 Pro into our oral screening standard of care. We find that using ViziLite Pro along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Pro is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Pro 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 Pro 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 \$30.00**

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

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

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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



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#

Emergency Contact Name and Number

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	Xgeva/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)**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Lung Disease      | <input type="checkbox"/> HIV Positive         |
| <input type="checkbox"/> Heart Failure/Attack    | <input type="checkbox"/> A1C Level             | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Autoimmune Disease   |
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Family History of     | <input type="checkbox"/> Emphysema         | (AIDS)  |
| <input type="checkbox"/> Heart Murmur            | Diabetes                                       | <input type="checkbox"/> Sleep Apnea       | <input type="checkbox"/> Thyroid Disease      |
| <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Artificial Joints     | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> Heart Surgery           | <input type="checkbox"/> Organ Transplant      | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Sjorens Syndrome     |
| <input type="checkbox"/> Congenital Heart        | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Fibromyalgia         |
| Problem  | <input type="checkbox"/> Bleeding Problem      | <input type="checkbox"/> Chemotherapy      | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Artificial Heart        | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Depression           |
| Valve/Stent                                      | <input type="checkbox"/> Blood Transfusion     | <input type="checkbox"/> Eating Disorder   | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Anemia                | <input type="checkbox"/> Acid Reflux/GERD  | <input type="checkbox"/> Epilepsy             |
| <input type="checkbox"/> Implanted Defibrillator | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Stomach Ulcer     | <input type="checkbox"/> Cerebral Palsy       |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Fainting/dizzy spells | <input type="checkbox"/> Liver Disease     | <input type="checkbox"/> Venereal Disease     |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Nervousness           | <input type="checkbox"/> Hepatitis A, B, C |   |

**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 QUESTIONNAIRE

*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 you 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 Acknowledgement 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 or Springstone/Lending Club (certain conditions are required as financing is through a third party and is subject to credit approval). In the event of a credit with Care Credit of Lending club – the credit must be refunded to the financing company first.

**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 its 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:** \_\_\_\_\_