



### Patient/Guardian Information

If different than the patient

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 Patient/Guardian

Employer Name: \_\_\_\_\_ Employer Phone \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Insurance Information

**Primary**  
Insurance Plan Name and Address: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Is the insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

**Secondary**  
Insurance Plan Name and Address: \_\_\_\_\_

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

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ 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 \_\_\_\_\_

### Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. We require 48 hours notice of a cancelled appointment or by 11:00 Friday morning if a Monday appointment or there will be a charge.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. I authorize Clearly Dental to bill and receive payments from my insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. There will be a \$25 service fee for all returned checks.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

Signature of patient, parent or guardian (seal) \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

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 are 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*

*-sexually active patients (HPV 16/18)*

*High risk: patients age 40 and older; tobacco users (any age, 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 might not be covered by your insurance. The fee for this enhanced examination is \$45.

**Yes.** I authorize the clinician to perform the ViziLite Plus 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 ViziLite Plus exam at this time.

Print name: \_\_\_\_\_

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



## Office Policies

### Please initial each statement

\_\_\_\_\_ As a courtesy, our office will submit claims to your insurance on your behalf. For any procedures not covered in full by your insurance, your portion will be estimated and due on the day of service. Although we try our best to estimate your portion accurately, it is your responsibility to know what your benefits are. The insurance policy is an agreement between you and the insurance company negotiated by your employer and is not a guarantee of payment. You are ultimately financially responsible for any services rendered.

\_\_\_\_\_ We do not offer in-office financing or payment plans, but do accept most major credit cards and are affiliated with CareCredit. They can be contacted on-line at Carecredit.com to apply and see what payment plans are available.

\_\_\_\_\_ Please be sure to notify the office of any changes in your contact information; such as, address, phone numbers, e-mail, etc. Also, if your insurance policy changes or is no longer in effect, it is your responsibility to let us know prior to your next appointment.

\_\_\_\_\_ If, for any reason, you cannot keep your scheduled appointment, please call the office with at least 48 hours notice or by 11am Friday if you are canceling a Monday appointment or there will be a charge. This allows us time to offer the appointment to another patient.

\_\_\_\_\_ As a courtesy, we will contact you to confirm a scheduled appointment. We have the capability to confirm appointments through e-mail and/or text messages. In addition to confirming appointments, e-mails can be used to notify you when you are due if you did not schedule in advance and to provide you with updates and office information. Please check all ways you authorize us to contact you.

\_\_\_\_\_ It is ok to send text messages.

\_\_\_\_\_ It is ok to call me at work

\_\_\_\_\_ It is ok to send e-mail messages

\_\_\_\_\_ We do our best to keep to a schedule. When a patient is late it is impossible to stay on schedule. If you arrive past your scheduled appointment time, the appointment may be rescheduled so that other patients are not inconvenienced. If you are a new patient, please arrive 10 minutes prior to your appointment time.

\_\_\_\_\_ Records generated by our office can be copied and mailed upon receipt of a signed records release form. There will be a charge to cover the cost of equipment, supplies and postage.

\_\_\_\_\_ We do not get involved in separation or divorce disputes between the guarantor of the account and the person who registers the child at the time of visits. Therefore, if the guarantor is delinquent in paying the account, the balance will be transferred to the person who registers the child at the time of the visit.

I have read the office policies and I understand and agree to the terms stated above.

Patients Name: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Guarantor: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

Clearly Dental  
1518 Churchville Rd  
Bel Air, MD 21014  
410-420-9822

I have received a copy of or am aware of how to obtain a copy of this office's Notice of Privacy Practices. Available upon request at the office.

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Please print patients name

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Signature (parent sign for minors)

I authorize you to speak to these people if necessary in regards to my treatment or bill.

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