ECCELLA™

Dr. Scott Wagner

SMILES | SKIN | SPORTS | WELLNESS

WELCOME.

We're glad you're here.

We know that going to the dentist may not be at the top of your "to do" list. But whether it's been six months or six years since your last visits, we're just glad that you are here.

We promise to listen to your hopes and fears, jitters and concerns. To provide care without pressure, and advice without obligation. To deliver equal doses of care and honesty, because we're confident you'll trust us with your mouth when you know we have your best interest at heart.

And we'll stop at nothing to deliver an experience that is above and beyond what you thought dental care could be.

WE THANK YOU,

ECCELLA TEAM

ECCELLA

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Patient Registration

Today's Date _____

Last Name _____ First Name _____ MI ____ Date of Birth _____ Age ____

Sex M or F Soc. Sec. # _____ Please Circle One: Single Married Separated Widow

Mailing Address _____ City _____ State ____ Zip Code _____

Email _____ Home Phone (____)_____ Cell Phone (____)_____

Driver's License # _____ Employer _____

Work Phone (____)_____ Occupation _____

Are you a full time student? Yes or No If patient is a minor: Mother's DOB _____ Father's DOB _____

Name of Parent _____ Parent Soc. Sec. # _____

Parent Employer _____ Parent Phone (____)_____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone # (____)_____

If you are filling this form out on behalf of another person, what is your relationship to that person?

Name _____ Relationship _____

Reason for today's visit? _____

How did you hear about us?

☐ In-home Mailer ☐ Social Media ☐ Insurance ☐ Practice Website ☐ Internet ☐ Family/Friend/Coworker

☐ Other_____ *Who can we thank for your visit?* _____

Dental Insurance Information (Primary Carrier)

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

Dental Insurance Information Secondary Coverage

Insured's Name _____

Insured's Employer _____

Insured's DOB _____

Insurance Co _____

Insurance Co Address _____

Insurance Phone # _____

Group # _____ Local # _____

Dental History

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

What would you like to change about your smile?

☐ Color ☐ Bite ☐ Chipped Teeth ☐ Spaces ☐ Crowding ☐ Smile Makeover ☐ Missing Teeth ☐ Whiter Teeth

Please share the following dates:

Your last cleaning ____/____ Your last oral cancer screening ____/____ Your last complete X-rays ____/____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

Why did you leave your previous dentist? _____

Name of your previous dentist _____

Dental History Cont. - Please mark (x) any of the following conditions that apply to you

Patient Name (print) _____

Appearance

- ☐ Discolored teeth
- ☐ Worn teeth
- ☐ Misshaped teeth
- ☐ Crooked teeth
- ☐ Spaces
- ☐ Overbite
- ☐ Flat teeth

Pain/Discomfort

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Pressure
- ☐ Broken teeth/fillings
- ☐ Worn teeth
- ☐ Dry Mouth

Function

- ☐ Grinding/Clenching
- ☐ Headaches
- ☐ Jaw Joint (TMJ) pain
- ☐ Jaw Joint (TMJ) clicking/popping
- ☐ Bad Bite
- ☐ Speech Impediment
- ☐ Mouth Breathing
- ☐ Sore Muscles (neck, shoulders)
- ☐ Difficulty Opening or Closing
- ☐ Difficulty Chewing on either side

Periodontal (Gum) Health

- ☐ Bleeding, Swollen, Irritated gums
- ☐ Bad breath
- ☐ Loose tipped, shifting teeth
- ☐ Previous perio/gum disease

Habits

- ☐ Thumb sucking
- ☐ Nail-biting
- ☐ Cheek/Lip biting
- ☐ Chewing on ice/foreign objects

Sleep Pattern or Conditions

- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Daytime Drowsiness
- ☐ Bed wetting (for children)

Social

Tobacco
How much ____How long ____

Alcohol Frequency_____

Drugs Frequency _____

Previous Comfort Options

- ☐ Nitrous Oxide
- ☐ Oral Sedation (Pill)
- ☐ IV Sedation

Please list family history of any conditions marked:

_____

_____

_____

_____

_____

_____

_____

Medical History - Please mark (x) to your response to indicate if you have or have had any of the following

Physicians Name: _____ Phone # _____ Date of last physical _____

Please circle "yes" or "no"

AID/HIV	Yes	No	Heart Murmur	Yes	No	Tuberculosis	Yes	No
Anemia	Yes	No	Heart Problem	Yes	No	Tumor or Growth	Yes	No
Arthritis, Rheumatism	Yes	No	Hepatitis Type ____	Yes	No	Ulcer	Yes	No
Artificial Heart Valves	Yes	No	High Blood Pressure	Yes	No	Cold Sore	Yes	No
Artificial Joints	Yes	No	Kidney Disease	Yes	No	Fever Blister	Yes	No
Asthma	Yes	No	Liver Disease	Yes	No	Headaches	Yes	No
Bleeding abnormally, with			Mitral Valve Prolapse	Yes	No	Jaw Pain	Yes	No
extractions, surgery, or cuts?	Yes	No	Nervous Problems	Yes	No	Jaw Popping	Yes	No
Blood Disease	Yes	No	Depression / Counseling	Yes	No	Limited Opening	Yes	No
Cancer	Yes	No	Psychiatric Care	Yes	No	Congested Ears	Yes	No
Chemotherapy	Yes	No	Pacemaker	Yes	No	Dizziness	Yes	No
Circulatory Problems	Yes	No	Radiation Treatment	Yes	No	Ringing Ears	Yes	No
Heart Lesions	Yes	No	Rheumatic Fever	Yes	No	Posture Problems	Yes	No
Cortisone Treatments	Yes	No	Scarlet Fever	Yes	No	Clenching	Yes	No
Cough, persistent	Yes	No	Sinus Trouble	Yes	No	Grinding	Yes	No
Diabetes	Yes	No	Stroke	Yes	No	Facial Pain	Yes	No
Epilepsy	Yes	No	Swollen Feet / Ankles	Yes	No	Neck Ache	Yes	No
Fainting or dizziness	Yes	No	Thyroid Problems	Yes	No	Bells Palsy	Yes	No
Glaucoma	Yes	No	Tonsillitis	Yes	No	Other (not listed)	Yes	No

Have you had a serious illness, operation, or hospitalization in the past 5 years? Y or N, If yes please explain _____

_____

_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Y or N If yes, please list all and why, including vitamins, natural or herbal supplements and/or dietary supplements _____

_____

_____

Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease?
If so, please list medications: _____

Have you ever had surgery? If so, what type: _____

_____

Consent:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____ _____ _____

Signature of Patient/Legal guardian *Print Name* *Date* *Dentist Signature*

For completion by dentist only | Additional Comments

_____

_____

_____

Financial Policy

Patient Name (print) _____

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment . Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please check if you would like more information about financing options. ☐

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

_____ _____

Patient Signature (Parent if child) *Date*

Patient Name (print) _____

Acknowledgement Of Receipt Of Notice Of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**** You may refuse to sign this acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Patient Name (Printed)

_____

Signature

_____

Date

Authorization To Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____

Name (Printed) *Relationship*

_____ _____

Name (Printed) *Relationship*

_____ _____

Name (Printed) *Relationship*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other *(Please Specify)*

_____

_____

_____

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ECCEllă™

Scott Wagner, DMD, LVIF

Oral Cancer Screening Consent Form

We are very concerned about oral cancer, and conduct screening examinations on every patient.

The incidence of Oral Cancer continues to rise in the USA. Approximately 45,750 people in the US will be newly diagnosed with oral cancer in 2015 and one American dies every hour of every day. **Alarmingly, 25 % of the new oral cancer cases are people that do not have any of the traditional life style risk factors, such as age and tobacco and alcohol use. Exposure to HPV (Human Papilloma Virus) is a newly discovered risk factor.**

Traditionally, dentists and hygienists have done oral cancer screening with the naked eye, but **with new technology, Visually Enhanced Lesion spectrum, will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.**

The enhanced light screening, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non invasive light that is shined into the patient's mouth. The images are viewed through the specialized glasses and the clinician may find tissue abnormalities at an earlier stage. Before the exam, the clinician will put on the specialized glasses and much like "dessert storm night vision technology" will be able to see changes in tissue that may not be visible to the eye. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

The enhanced light testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. However, the exam may or may not be covered by dental insurances. *The fee for this enhanced examination is $30.* **As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure.**

Please sign the area below to accept the financial responsibility for this procedure. Once again, we feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients.

Thank you for your kind consideration.

YES, I authorize the office to perform the VELscope examination.

Print Name_____

Signature_____ Date _____

NO, I understand the risks and choose not to have the VELscope examination.

Print Name _____

Signature_____ Date _____