

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I have been given a copy of Edgewood Dental, LLC's *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that the Practice has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:

Signature of Patient or Personal Representative

Date

Print Name

Personal Representative's Title (e.g., Guardian, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

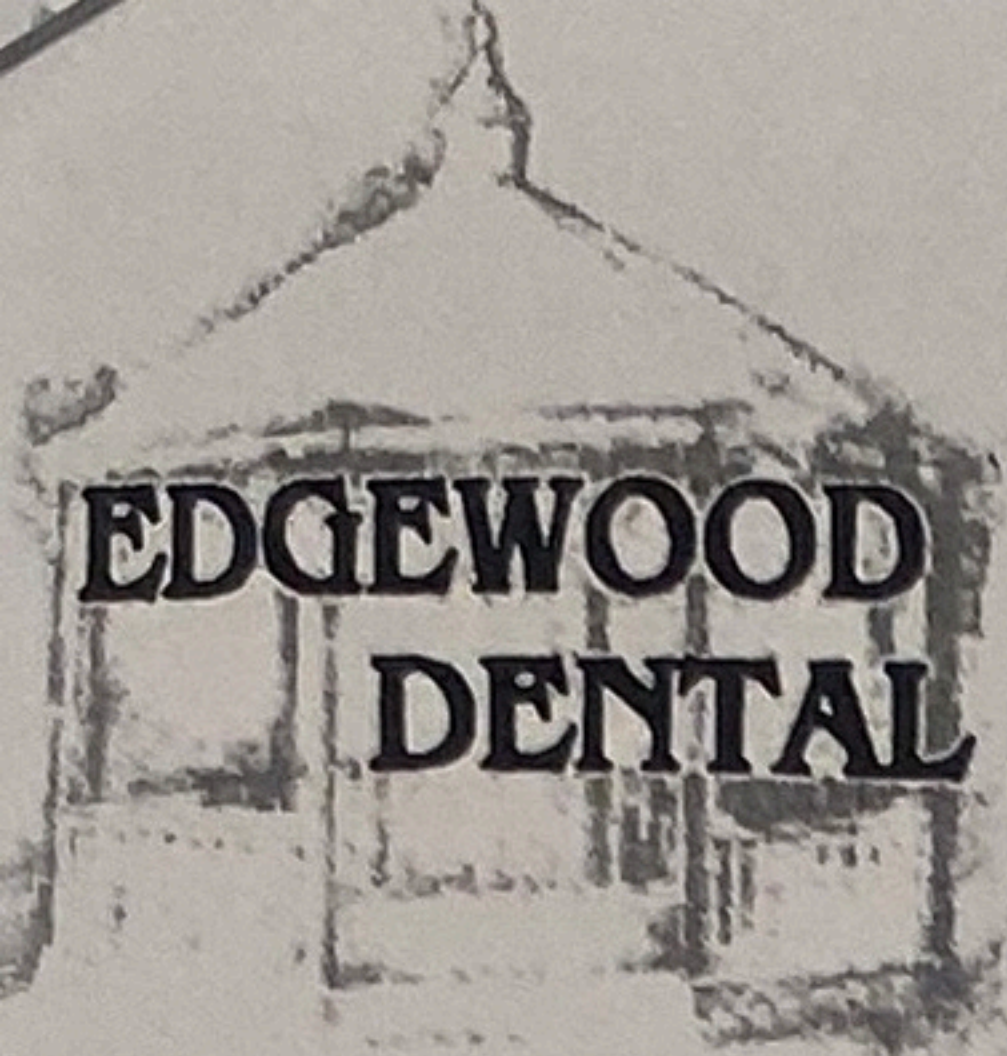
Completed by:

Signature of Practice Representative

Date

Print Name and Title

File Original in Patient's Health Care Record



Dear valued Patient:

It is our goal to provide our family of patients with the highest degree of care. Therefore, we are making available to you, oral cancer detection with *VELscope*. *VELscope* is a system currently being used to diagnosis early stages of oral cancer. In most cases by the time lesions are visually detected they are in stage III or IV and patients usually do not have positive prognosis. Healthcare institutions across the country are verifying the positive diagnostic results of the *VELscope*. It is a simple non-invasive tool that is used in conjunction with the visual inspection done at your preventive visit every six months. We recommend *VELscope* testing on an annual basis; unless a patient has suspicious lesions then more frequent testing would be recommended. Early detection is saving lives. Studies have shown that you do not need to be a smoker or drinker to have oral cancer.

Since most insurance companies are not up to date on the most recent diagnostic services available they have not yet recognized the use of the *VELscope* for oral cancer examination. Patients choosing to have the procedure will be responsible for the \$39 evaluation fee. Whether or not you elect to have the *VELscope* examination, we ask that you kindly check the box below and remit with your signature.

☐ I would appreciate the *VELscope* examination.

☐ I do not want the *VELscope* examination.

Signed: _____ Date: _____

Update:

Date: _____ ☐ Accept ☐ Decline Signed: _____

Date: _____ ☐ Accept ☐ Decline Signed: _____

Date: _____ ☐ Accept ☐ Decline Signed: _____

Date: _____ ☐ Accept ☐ Decline Signed: _____

PATIENT REGISTRATION

DATE: _____

NAME: _____
LAST FIRST M☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALEADDRESS: _____
STREET APT# CITY STATE ZIPBIRTHDATE: _____ TELEPHONE: _____
MO DAY YEAR HOME OFFICEEMPLOYER: _____ FULL TIME STUDENT ☐ SCHOOL ATTENDING: _____
NAME ADDRESS

SOCIAL SECURITY NO: _____ Whom may we thank for referring you to our office? _____

**PERSON RESPONSIBLE
FOR ACCOUNT**

NAME: _____

State Driver's License Number: _____

**ACCOUNT & INSURANCE
REGISTRATION**

(FILL IN BOTH BLOCKS)

SELF/(OR FATHER IF MINOR CHILD)

SPOUSE (OR MOTHER IF MINOR CHILD)

NAME:

ADDRESS:

TELEPHONE#:

BIRTHDATE/SS#

EMPLOYER

DENTAL
INSURANCE CO:

GROUP #:

SELF/(OR FATHER IF MINOR CHILD)				SPOUSE (OR MOTHER IF MINOR CHILD)			
LAST	FIRST	M		LAST	FIRST	M	
STREET CITY STATE ZIP				STREET CITY STATE ZIP			
MO	DAY	YEAR	SS#	MO	DAY	YEAR	SS#
EMPLOYER				EMPLOYER			
DENTAL INSURANCE GROUP#				DENTAL INSURANCE GROUP#			

**PERSON TO CONTACT OUTSIDE OF
IMMEDIATE FAMILY / HOUSEHOLD
IN CASE OF EMERGENCY**NAME: _____ TEL# _____
LAST FIRST MADDRESS: _____
STREET CITY STATE ZIP**AUTHORIZATION**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

PLEASE NOTE: Appointments are reserved in advance that you may have sufficient time to check your schedule for any personal conflicts. Changes in your appointment affect many patients. Please do not make appointment changes, unless an emergency arises. A minimum of \$75.00 may be charged for broken appointments. Please don't let this happen.

X _____ Date: _____
☐ Adult Patient ☐ Husband (or Father) ☐ Wife (or Mother) ☐ Guardian

PATIENT INFORMATION

Pharmacy Name: _____ Phone: _____

PLEASE CIRCLE

[illegible]

YES	NO
YES	NO
YES	NO
YES	NO

YES	NO
YES	NO
YES	NO
YES	NO

YES	NO
YES	NO
YES	NO
YES	NO

YES	NO
YES	NO
YES	NO
YES	NO

Hypoglycemia
Psychiatric Care
Drug Addiction
Blood Transfusion
Hemophilia
AIDS (HIV)
Venereal Disease
Cold Sores
Fever Blisters
Herpes
Bruise Easily
Sickle Cell Anemia

YES	NO
YES	NO
YES	NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO