ECCELLA SMILES
DENTISTRY DEFINED

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 visit, 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,

DR. SCOTT WAGNER &

THE ECCELLA TEAM

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Today's Date _____

Patient Registration

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's 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)

Policyholder Name
_____
Policyholder Employer
_____
Policyholder's DOB
_____
Insurance Co.
_____
Insurance Co. Address
_____
Insurance Phone #
_____
Group # _____ Local # _____

Dental Insurance Information (Secondary)

Policyholder Name
_____
Policyholder Employer
_____
Policyholder's DOB
_____
Insurance Co.
_____
Insurance Co. Address
_____
Insurance Phone #
_____
Group # _____ Local # _____

Dental History

Patient Name (print) _____

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 _____

Please mark (X) any of the following conditions that apply to you

Appearance
☐ Discolored teeth
☐ Wom 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)

Previous Comfort Options
☐ Nitrous Oxide
☐ Oral Sedation (Pill)
☐ IV Sedation

Social
☐ Tobacco
How much? _____
How long? _____
☐ Alcohol Frequency
_____
☐ Drugs Frequency
_____

Please list family history of any conditions marked:
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Medical History

Physician's 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/fever blister	Yes No
Artificial Joints	Yes No	Kidney Disease	Yes No	Headaches	Yes No
Asthma	Yes No	Liver Disease	Yes No	Jaw Pain	Yes No
Bleeding abnormally, with		Mitral Valve Prolapse	Yes No	Jaw Popping	Yes No
extractions, surgery, or cuts?	Yes No	Nervous Problems	Yes No	Limited Opening	Yes No
Blood Disease	Yes No	Depression/Counseling	Yes No	Congested Ears	Yes No
Cancer	Yes No	Psychiatric Care	Yes No	Dizziness	Yes No
Chemotherapy	Yes No	Pacemaker	Yes No	Ringing Ears	Yes No
Circulatory Problems	Yes No	Radiation Treatment	Yes No	Posture Problems	Yes No
Heart Lesions	Yes No	Rheumatic Fever	Yes No	Clenching	Yes No
Cortisone Treatments	Yes No	Scarlet Fever	Yes No	Grinding	Yes No
Cough, persistent	Yes No	Sinus Trouble	Yes No	Facial Pain	Yes No
Diabetes	Yes No	Stroke	Yes No	Neck Ache	Yes No
Epilepsy	Yes No	Swollen Feet/Ankles	Yes No	Bells Palsy	Yes No
Fainting or Dizziness	Yes No	Thyroid Problems	Yes No	Other (not listed)	Yes No
Glaucoma	Yes No	Tonsillitis	Yes No	_____	

Are you allergic to any of the following? ☐ Aspirin ☐ Metal ☐ Penicillin ☐ Codeine
☐ Latex ☐ Sulfa Drugs ☐ Acrylic ☐ Local Anesthetics
☐ Other allergies? If yes, please list _____
_____

Have you had a serious illness? Y or N, if yes, please explain _____
_____

Have you ever been hospitalized or had any surgeries? Y or N, if yes, what type: _____
_____

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 now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease? If so, please list medications: _____
_____

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*

Financial Policy

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 of service provided. Our office accepts cash, personal checks, credit cards and outstanding 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.
- As a courtesy to you, we will help 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*

Cancellation Policy

Eccella Smiles reserves 2 hours for your "New Patient Appointment." To reserve your first appointment with us, Eccella Smiles requires a credit card to be placed on file. In the event that the appointment is cancelled without 48 hours notice, the credit card on file will be charged a $100 broken appointment fee. Please understand that your appointment is reserved just for you. It is your time with your doctor and/or hygienist. We do not "double book" appointments. If you must change an appointment, cancellations must be confirmed with an Eccella staff member at least 48 hours prior to your scheduled appointment. Emails and voicemails will NOT be accepted for cancelling an appointment. **Otherwise, we reserve the right to charge broken appointment fees for the value of your scheduled appointment, as follows: New Patient Appointment cancellations are subject to a $100 fee, Doctor appointments are subject to a $150/hour fee, and Hygiene appointments are subject to a $100 per hour fee.** Please help us serve you better by keeping scheduled appointments. We never want to charge a broken appointment fee, so please work with us to avoid this situation. Here at Eccella we pride ourselves on great communication and we try to be understanding of extenuating circumstances. Open communication is key to building great relationships. We value your time highly and do our best to stay on time.

Patient Signature _____ 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

☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other *(Please Specify)*

_____

_____

_____

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 require further examination and follow up.

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 "desert storm night vision technology" will be able to see changes in tissue that may not be visible to the naked 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 _____