DAVIDIAN FAMILY AND COSMETIC DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ***(patient or legal guardian)*** _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Patient Name Above

_____
Signature (patient or legal guardian)

_____

Patient Address

_____
Date

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 for the following reason:_____
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ A copy was mailed with a request for a signature by return mail
- ☐ Other (Please Specify) _____

  _____

Prepared by (print name of office employee):_____

Signature: _____ Date:_____

REQUEST AND CONSENT FOR DENTAL TREATMENT

Patient Name: _____
Legal Guardian (If patient is under 18 years of age): _____

Please initial beside the following lines. By initialing, you signify you fully understand the statement and/or our office policies.

I request and authorize Dr. Melissa Davidian, assistants and dental hygienists to perform the following treatment/ procedure(s):

_____ **FOR ALL NEW PATIENTS**: Oral Evaluations, Prophy/cleaning, radiographs.

_____I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary and/ or advisable by the doctor responsible for my treatment.
_____ I fully disclosed all health problems, including but not limited to: heart conditions, high/low blood pressure, diabetes, need for antibiotics prior to dental treatment (due to prosthetic valves, joints or heart conditions), medications taken/prescribed, bleeding problems, and allergies.

If you are receiving dental treatment other than an exam, dental cleaning and radiographs, please read and initial beside the Description of Treatment/Procedure(s):

Scaling and root planing (deep cleaning) _____
Extraction of tooth _____
Root Canal Therapy _____
Fillings, Bridges, Crowns _____
Complete or Partials Dentures _____
General or Conscious Anesthesia _____
Other (Ex: Biopsy, Arestin, Periochip) _____

_____**For Oral Surgery:** The extraction of a tooth is an irreversible process and whether routine or difficult, it is a surgical procedure. In any surgery, there are some risks. These risks include, but are not limited to, the possibility of pain or discomfort during and after the following treatment, swelling, infection, bruising, dry socket (due to dislodged blood clot), bleeding, injury to adjacent teeth (especially with large fillings, decay or crowns) and surrounding tissue, TMJ disorder, limited jaw opening of or displacement of a tooth or portion thereof into the sinus (especially with upper back teeth) or other anatomic location requiring additional surgery (and possible referral to Oral Surgeon) to close the opening or recover the tooth structure, temporary or permanent numbness, jaw fracture and allergic reactions. In addition, the decision to leave a small piece of root in the jaw when its removal would require extensive surgery may be necessary. To avoid injury to vital structures such as nerves or the sinus, small root tips may be left in place. Sharp ridges, or bone splinters may form later at the edge of the socket and may require another surgery to smooth or remove. The usual and most frequent risks and complications occurring from the planned treatment have been explained to me and by signing this form, I consent to the extraction of the above tooth/teeth.

_____**For Dentures and Partial Dentures:** I realize that full or partial dentures are artificial and the problems of wearing these appliances have been explained to me (including, but not limited to, looseness, soreness, and possible breakage). I realize the final opportunity to make changes in my new dentures (including shape, size, placement and color of the teeth) will be the "teeth in wax" try-in visit. I understand the appliance may need to be relined 3-15 months after fabrication and the cost for this is not included in the initial denture. There may be additional charges for denture/partial adjustments in the future.

_____**For Crowns and Bridges:** I understand it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand I will be wearing temporary crowns and will ensure that they are kept on the tooth until the definite crown/bridge is cemented. I will verify the shape, color and size at the first appointment as the crown will be ready to cement at the following appointment. Endodontic procedures (root canals) are sometimes necessary after the preparation for the crown; root canals are a separate procedure and you may need to see a specialist if a root canal is needed. For implant crowns, we are not responsible for the successful placement and guarantee of the implant as we did not perform the implant placement.

_____**For Endodontic Treatment (Root Canal):** I realize there is no guarantee that root canal treatment will save my tooth, and that a complication can occur from the treatment that may necessitate the extraction of the tooth. Occasionally metal objects are cemented in the tooth or extend through the root, which may/may not necessarily affect the success of the treatment. I understand there is considerable risk of instrument separation during root canal treatment in which referral to an Endodontist may be necessary to evaluate the situation, complete root canal treatment and /or perform surgical procedures to increase the root canal success. I understand that occasionally additional surgical procedures may be necessary following root canal treatment, root canals may have to be retreated, referral to an Endodontist (Ex: complicated root canal anatomy, inability to locate canals, calcified canals) may be necessary. If a tooth fracture is present, it may not be visually detected but may lead to the loss of the tooth, even after a root canal is performed.

_____ **For Conscious Sedation:** I understand I am not to drive after taking medications for dental anxiety. In addition, I will not operate machinery for the remainder of the day. I am not allergic to benzodiazepines (Valium, Triazolam, Versed, Ativan, etc.), pregnant or breast feeding, nor do I have liver or kidney disease. I have not consumed alcoholic beverages in the past 12 hours, nor have I used illicit drugs. Side effects may include light-headedness, headache, dizziness, visual disturbances, amnesia, and nausea. In some people, such as smokers, oral sedative may not work as desired. On the way home, your seat in the car should be in the reclined position. When at home, lie down with your head slightly elevated. Someone should stay with you for the next several hours due to possible disorientation and possible injury from falling.

_____ **Children:** Should at anytime a child/dependent become uncooperative during treatment with movement of the head, arms and/or legs, it may be necessary to terminate treatment. If a decision is made to terminate care, the current procedure being performed will be brought to a logical closure. Logical closure requires the cooperation of the patient in order to prevent pain and infection that can result from open teeth. During disruptive behavior incidents, it may be necessary for the assistant(s) to hold the patients hands, stabilize the head, and/or control leg movement in order to close a tooth. A bite block may be necessary to maintain mouth opening.

_____ During the course of treatment, complications may arise that may necessitate additional procedures or alter the proposed course of treatment. Such complications may include, but are not limited to, the need for a root canal and or extraction. I acknowledge the practice of dentistry is not an exact science and offers no guarantees. When administering anesthetic, there is a rare but unavoidable risk of possible nerve damage, paralysis and/or dysthesia. These complications may be temporary or permanent.

SIGNATURE OF PERSON CONSENTING TO TREATMENT: I have had sufficient opportunity to discuss the treatment plan, the benefits to be reasonably expected from this treatment, as well as the alternative approaches, including no treatment. All of my questions have been answered to my satisfaction, and I consent to the treatment and procedures prescribed. I confirm I have read this form or it was read to me.

Patient or Guardian Signature: _____
Print Name: _____ **DATE:** _____
Relationship: _____

SIGNATURE OF DENTIST: _____ **Date:** _____

Patient Information **Date: _____**

Last Name: _____ First: _____MI:___ Preferred Name: _____

Address: _____ City: _____ State/Zip: _____

Birth date: _____ SSN: _____ Sex: ____ Marital Status: _____

Patient Employer / School: _____ Occupation: _____

Employer / School Address: _____ Phone: _____

Spouse Name: _____ Birth date: _____ SSN: _____

Who may we thank for referring you? _____

Phone Numbers / E-mail

Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

E-mail: _____ Best time and place to reach you:

_____

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Home Phone: (_____) _____ Other Phone: _____

Dental History

Reason for today's visit: _____

Previous Dentist Name and Address: _____

What was done at your last dental visit: _____

Date of last dental cleaning: _____ Date of last x-ray: _____

Are you having any dental problems now? _____ Are you curious about cosmetic options? _____

How often do you: Have examinations _____ Brush _____ Floss _____

Indicate if you have had or presently have any of the following:

Sensitivity to Hot or Cold	Y	N	Difficulty opening /closing mouth	Y	N
Sensitivity to Sweets	Y	N	Head, Neck, or Shoulder aches	Y	N
Biting or Chewing Pain	Y	N	Have tired jaws, especially in the morning	Y	N
Mouth odors / Halitosis	Y	N	Mouth breathe while awake or asleep	Y	N
Cold Sores / Oral Lesions	Y	N			
Bleeding / Swollen Gums	Y	N	Orthodontic treatment	Y	N
Family History Gum Disease	Y	N	Oral Surgery	Y	N
Loose teeth / Change in bite	Y	N	Serious injury to the mouth or head	Y	N
Food collection between teeth	Y	N	If so, please describe: _____		
Periodontal treatment/surgery	Y	N	Do you have well water?	Y	N
Clenching or grinding of teeth	Y	N	Are you satisfied with the appearance of your teeth?	Y	N
Bite lips or check regularly	Y	N	Do you feel nervous about having dental treatment	Y	N
Clicking or popping of the jaw	Y	N	If so, what is your biggest concern: _____		

Is there anything else about having dental treatment that you would like for us to know? If yes, please describe:

_____

Health History

1. Have you been under the care of a medical doctor and/or been hospitalized during the past 2-5 years? Y N
If yes, please describe: _____

2. Physician's Name, address, and phone #: _____

3. Indicate which of the following you have had, or have at present.

Heart (Surgery, Disease, Attack)	Y	N	Ulcers or gastric reflux	Y	N	Hepatitis	Y	N
Chest Pain / Angina	Y	N	Diabetes: Type I or II	Y	N	STD	Y	N
Congenital Heart Disease	Y	N	Thyroid Problems	Y	N	AIDS / HIV	Y	N
Heart Murmur / or Defects	Y	N	Glaucoma	Y	N	Cold Sores	Y	N
High / Low Blood Pressure	Y	N	Contact Lenses	Y	N	Blood transfusion	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N	Hemophilia	Y	N
Artificial / Damaged Heart Valve	Y	N	Tuberculosis	Y	N	Sickle Cell	Y	N
Heart Pacemaker	Y	N	Chronic cough	Y	N	Bruise Easily	Y	N
Stroke	Y	N	Asthma	Y	N	Liver Disease	Y	N
Rheumatic Fever	Y	N	Hay Fever, Sinus trouble	Y	N	Yellow Jaundice	Y	N
Arthritis / Rheumatism	Y	N	Latex Sensitivity	Y	N	Neurological	Y	N
Cortisone Medicine	Y	N	Allergies or Hives	Y	N	Disorders	Y	N
Swollen ankles	Y	N	Migraines	Y	N	Epilepsy/Seizures	Y	N
Diet (Special/Restricted)	Y	N	Radiation/Chemo Therapy	Y	N	Fainting or		
Artificial Joints (hip, knee etc.)	Y	N	Cancer	Y	N	Dizzy Spells	Y	N
Kidney Trouble	Y	N	Tumors	Y	N	Psychiatric /	Y	N
Frequent Urination	Y	N	Sleep Disorders	Y	N	Psychological Care		
Women:								
Pregnant	Y	N	Nursing	Y	N	Birth Control	Y	N

Do you drink alcoholic beverages? Y N
Have you ever had a chemical dependency? Y N
Do you use drugs, tobacco products or any other substance? If yes, please list and frequency of use: Y N

Medications

1. Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? Y N
If yes, please name Physician/dentist name and antibiotic given. _____

2. List any medications you are currently taking and the correlating diagnosis: _____

Allergies / Reactions

Amoxicillin	Y	N	Aspirin	Y	N	Augmentin	Y	N	Cephalosporin	Y	N
Ciproflaxin	Y	N	Clindamycin	Y	N	Codeine	Y	N	Erythromycin	Y	N
Morphine	Y	N	Penicillin	Y	N	Sulfa	Y	N	Vicodin	Y	N
Latex	Y	N	Other: _____								

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should additional information be needed you have my permission to ask the responsive health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or edications.

Signature of Patient or Legal Guardian: _____ Date: _____

Print Name: _____ Date: _____

UPDATE:

Please note any changes: _____

Medications: _____

Date Reviewed: _____ Signature of Patient: _____ Initial: _____

UPDATE:

Please note any changes: _____

Medications: _____

Date Reviewed: _____ Signature of Patient: _____ Initial: _____

UPDATE:

Please note any changes: _____

Medications: _____

Date Reviewed: _____ Signature of Patient: _____ Initial: _____

UPDATE:

Please note any changes: _____

Medications: _____

Date Reviewed: _____ Signature of Patient: _____ Initial: _____

UPDATE:

Please note any changes: _____

Medications: _____

Date Reviewed: _____ Signature of Patient: _____ Initial: _____

CONSENT TO RELEASE / REQUEST DENTAL RECORDS

I, _____, do hereby consent and authorize _____ to disclose
(Patient name) ***(Previous Dental /Medical office)***
to Dr. Melissa Davidian, DDS information in my record, including current and previous dental records from other practitioners, hospitals and/ or clinics which are part of my record.

My date of birth is _____ and my social security number is _____.
(Patient date of birth) ***(Patient social security number)***

This information is strictly for the purpose of identification.

I also consent to the release of dental records by Davidian Family and Cosmetic Dentistry in the event any additional information is needed by my insurance company or other providers.

Patient or guardian signature: _____

Print: _____

Relationship to patient: _____

Date: _____

Please send this to: Davidian Family and Cosmetic Dentistry
Melissa C. Davidian, DDS
12740 Spruce Tree Way, Suite 104
Raleigh, NC 27614

If you have any questions, please call our office: 919-562-2345

Copies of the following records are specifically requested:

- Progress notes
- Letters/Reports to/from Specialist
- Periodontal Charting
- Radiographs
- Medical History Forms

Davidian Family & Cosmetic Dentistry
Melissa C. Davidian, DDS

Financial Statement

The following Financial Policy is required prior to any dental treatment. Please understand we do not want to see financial constraints and/or broken appointments interfere with dental care and the doctor/patient relationship. To facilitate your payments, the following options are listed. Please read them carefully, initial and sign all designated lines.

Patient Name: _____
Name of Person Responsible for Account: _____
Relationship to Patient: _____
Drivers License #: _____ **State:** _____ **Exp. Date:** _____
Date of Birth: _____ **SS#** _____
Employer Name & Work Phone #: _____

Payment Options

IF YOU DO NOT HAVE INSURANCE, payment is due in full at the time treatment is provided. For your convenience, we accept Cash, Personal checks, MasterCard, Visa, and CareCredit financing, pending credit approval. _____(Initial)

IF YOU HAVE INSURANCE, we will submit your insurance claim to your insurance carrier as a courtesy to you. The amount of coverage paid by your insurance company may be based on your insurance company's Usual and Customary Rates and/or Fee Schedule. Please note, we are not contracted with any insurance company. You are responsible at the time of your appointment for any deductible or co-payment not covered by the insurance company, as well as any remaining balance that the insurance company fails to pay. If your insurance company does not remit payment within 60 days, the balance will be due from you and may be subject to service charges. _____ (Initial)

Broken Appointment Policy

Appointments in our office are reserved exclusively for each patient and are also customized according to individual needs. For this reason, if you are unable to keep your reserved appointment, please give us at least 24 hours notice. If you have a Monday appointment and need to cancel or reschedule, you need to contact our office no later than Thursday, the week before. We charge $50 per hour scheduled for all broken appointments, no shows, and rescheduled appointments if less than 24 hour notice is not given. _____ (Initial)

If a second broken appointment occurs, we will NOT reschedule your appointment at that time. Instead, we will place you on a short-notice list and we will call you when we have an appointment time available. In addition, you will also be required to PRE-PAY for your next appointment in FULL, as well as any broken appointment fees. _____ (Initial)

In the event you break an appointment for the 3rd time, we will NOT reschedule your appointment. We will provide 30 days emergency care, to allow you time to find another dental provider. _____ (Initial)

Additional Costs

I understand and agree to pay for ALL cost involved with a collection agency, small claims court and/or an attorney's fees if my account is not paid for in full. _____ (Initial)

Returned Checks

There will be a $25.00 returned check fee applied to your account if a check is returned. The account then must be paid by Cash, MasterCard or Visa. _____ (Initial)

Signature of Responsible Party: _____ Date: _____

Adjunctive Oral Cancer Screening Acceptance Form

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

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.**

Oral Cancer Risk profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with any of the following:
  - Tobacco use
  - Chronic alcohol consumption
  - Oral HPV infection

Highest risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer

• 25% of oral cancers occur in people who don't smoke and have no other risk factors.

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is $_____.

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: _____

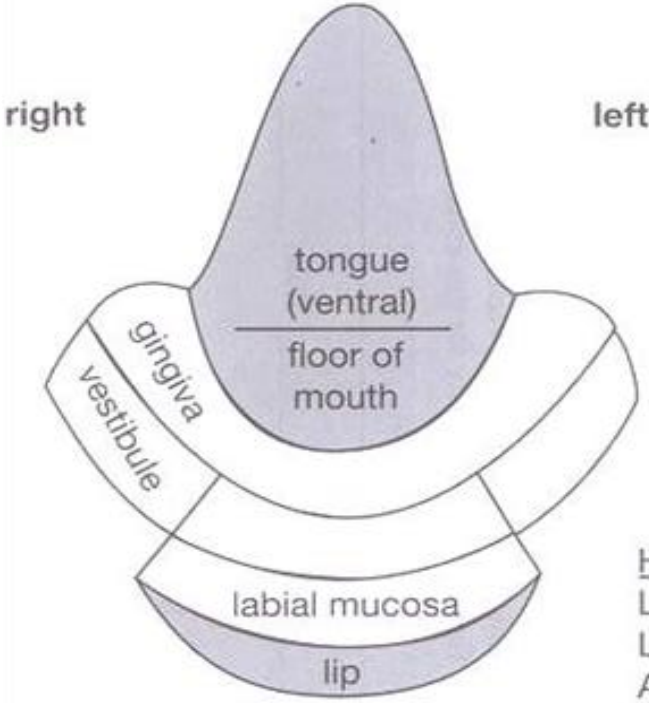
No. I would prefer not to have the ViziLite Plus exam at this time.

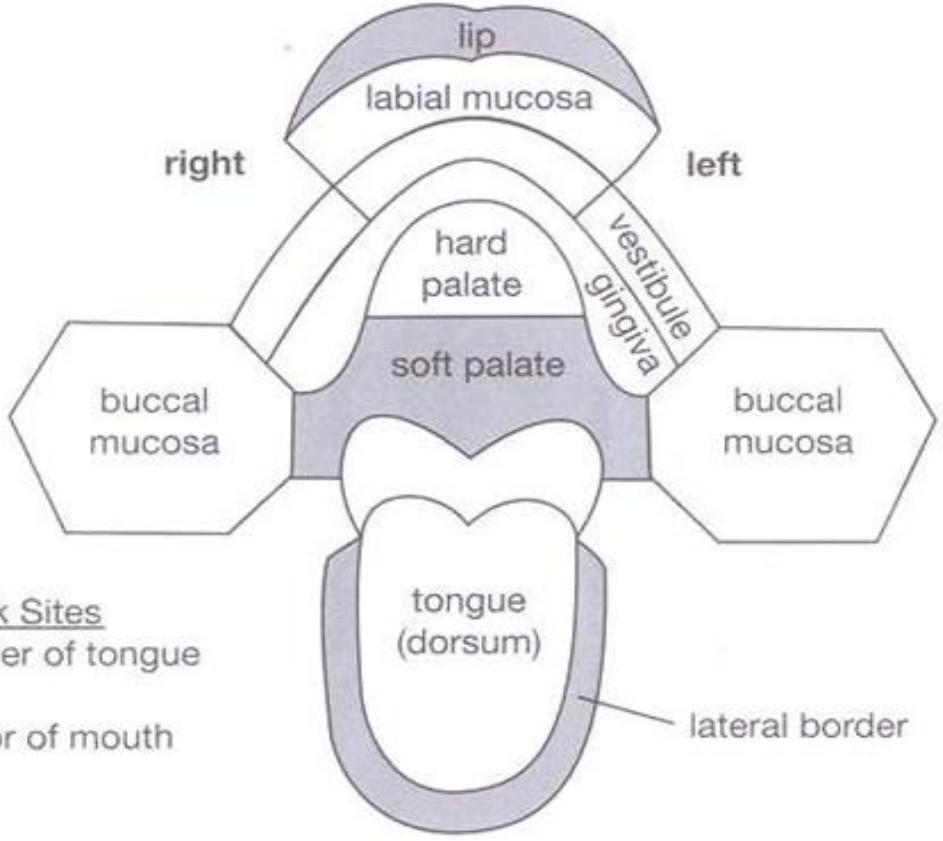
Print name: _____

ViziLite Plus
ORAL LESION IDENTIFICATION AND MARKING SYSTEM
with TBLUE

Patient _____ ID _____

Clinician _____ Date _____





Highest Risk Sites
Lateral border of tongue
Lip
Anterior floor of mouth
Soft palate