WILLIAM N. CUMMINGS D.M.D.

Avondale Dentistry

Patient Records Release Form

I hereby request a copy of my dental records from the office of

Dr. _____

Phone #:_____

Fax #:_____

Patient Name:_____

Parent (If under age of 18):_____

Signature:_____ Date:_____

Please send the latest radiographs to:

Dr. William Cummings DMD

ContactUs@AvondaleDentistry.com

Office: (610) 268-8300 Fax: (610) 268-8329
8830 Gap-Newport Pike, Avondale, PA 19311
ContactUs@AvondaleDentistry.com
www.AvondaleDentistry.com

This information is necessary for our files and your health and will be considered CONFIDENTIAL.

Patient Information

Date _____

Name _____ (Last) _____ (First) _____ (Middle)

Mr Miss Mrs Ms Dr Marital Status: Single Married Divorced Widowed

I prefer to be called _____ Birthdate _____

Address _____ (Street)

_____ (City) _____ (State) _____ (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail Address _____

Employer _____ Occupation _____ SS# _____

Business address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Spouse or Legal Guardian Information

Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street)

_____ (City) _____ (State) _____ (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate _____ SS# _____ Relationship _____

Employer _____ Occupation _____

Business address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Dental History

1. Are you having any discomfort at this time? ..... Yes No
   If yes, please describe. _____
2. Have you ever had any serious trouble related to previous dental treatment? ..... Yes No
   If yes, please explain. _____
3. Does dental treatment make you nervous? No / Slightly / Moderately / Extremely
4. Date your last dental visit? _____ Treatment provided _____ Cleaning? _____
5. Have you ever been treated for Periodontal Disease (Gum disease, pyorrhea, trench mouth)?
   If yes, when _____ By Whom? _____
6. Are you concerned about offensive breath odor? ..... Yes No
7. Would you like to have fresher breath? ..... Yes No
8. Are you allergic to any metals? What type? ..... Yes No
9. Have you ever had a skin reaction to jewelry? ..... Yes No
10. Are you satisfied with your smile? ..... Yes No
    If no, how would you improve it? _____
11. Would you like whiter teeth? ..... Yes No
12. What are you looking for in your new Dentist? _____
13. Why did you leave your last Dentist? _____
14. What do you expect to have done during your first dental visit? _____
15. Please give the name and telephone # of the closest relative (not living with you) to contact in case of an emergency.
    _____

We are almost exclusively a referral practice and we highly value those who have recommended you.
How did you hear about our office? _____

Consent for treatment: I hereby permit any treatment necessary to my dental care to include the administration of anesthetics, analgesics, sedatives, and nitrous oxide sedation, but only after these contemplated treatments and administrations have been fully and thoroughly explained to my satisfaction to include possible risks and adverse effects of both procedures, anesthetics and drugs that may be employed. By my signature I acknowledge that I have read, understood, and accurately answered all items on this page.

Signature _____ Date _____

OVER

Health History

CIRCLE

1. Have you been a patient in the hospital during the past two years? ..... Yes No
2. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   Physician's Name _____
   Address _____ Phone # _____
3. Have you taken any medicine or drugs during the past two years? ..... Yes No
   Are you now taking any medication, drugs or pills? ..... Yes No
   If yes, please list: _____
4. Are you allergic or have you reacted adversely to any of the following substances? ..... Yes No

Aspirin	Nitrous Oxide	Valium	Penicillin
Darvon	Erythromycin	Scopolamine	Other Antibiotics
Codeine	Tetracycline	Local Anesthetic (Novacaine or Xylocaine)	
Demerol	Percodan	Nembutal / Seconal (Sleeping Pills)	
Latex Gloves	Metal allergy	Sulfa	

5. Are you aware of being allergic to any other medications or substances? ..... Yes No
   If yes, please list: _____
6. Circle any of the following which you have had or have at present:

1. Heart Failure
2. Heart Disease or Attack
3. Angina Pectoris
4. High Blood Pressure
5. Heart Murmur
6. Rheumatic Fever
7. Congenital Heart Lesions
8. Artificial Heart Valve
9. Heart Pacemaker
10. Heart Surgery
11. Artificial Joints (Hip, Knee)
12. Anemia
13. Stroke
14. Kidney Trouble
15. Ulcers
16. Cosmetic Surgery
17. Emphysema
18. Cough
19. Tuberculosis (TB)
20. Asthma
21. Hay Fever
22. Sinus Trouble
23. Allergies or Hives
24. Diabetes
25. Thyroid Disease
26. X-ray or Cobalt Treatment
27. Chemotherapy (Cancer, Leukemia)
28. Arthritis
29. Rheumatism
30. Cortisone Medicine
31. Glaucoma
32. Pain in Jaw Joints
33. Frequent Headaches
34. A.I.D.S. / HIV
35. Hepatitis A (infectious)
36. Hepatitis B (serum)
37. Liver Disease
38. Osteoporosis
39. Blood Transfusion
40. Drug Addiction
41. Hemophilia
42. Venereal Disease (Syphilis, Gonorrhea)
43. Cold Sores / Fever Blisters
44. Epilepsy or Seizures
45. Fainting or Dizzy Spells
46. Nervousness
47. Sickle Cell Disease
48. Psychiatric Treatment
49. Bruise Easily
50. Periodontal (Gum) Disease
51. High Decay Rate ("Soft Teeth")
52. Poor Occlusion (Bad Bite)
53. Tobacco Use
54. Mitral Valve Prolapse
55. Family History of:
    _____Diabetes
    _____Heart Disease
    _____Poor Gums
    _____Soft Teeth
    _____Other _____
56. Poor Nutrition

CIRCLE

7. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are tired? ..... Yes No
8. Do your ankles swell during the day? ..... Yes No
9. Have you ever taken antibiotic prior to dental treatment? ..... Yes No
10. Have you even taken any medication to aid in weight loss? ..... Yes No
    If so, specify name of medication: _____
11. Has your medical doctor ever said you have cancer or a tumor? ..... Yes No
12. Do you have a disease, condition, or problem not listed? _____

FOR WOMEN ONLY:

Are you pregnant? ..... Yes No
If yes, what month? _____
Are you taking birth control pills? ..... Yes No

All questions asked on this history form are important in arriving at a diagnosis and a treatment plan; all questions must be answered: if a medical condition not related to any other questions on this form is known, it should be reported to the Doctor. I have read, understood and complied with this request to the best of my ability. If any change occurs in my health or in any of the information provided above I will report it to the dental office as soon as possible.

Patient Signature: _____ Date: _____

OVER

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____

Please **print** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents:_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes stepparents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship:_____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone
- ☐ Home Phone
- ☐ Work Phone
- ☐ Text Message
- ☐ Email
- ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES EVENTS FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- ☐ Cell Phone
- ☐ Home Phone
- ☐ **Any of the Above**
- ☐ Text Message

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

_____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because: It was emergency treatment
I could not communicate with the patient
The patient refused to sign
The patient was unable to sign because
Other (please describe) _____
Signature of Privacy Officer: _____

FINANCIAL AND INSURANCE POLICY

Patient's Primary Insurance Information:

Insured Name _____ Birthdate _____

Social Security Number _____ Insurance ID _____

Employer _____ Insurance Company Name _____

Group # _____ Insurance Co. Phone # _____

Secondary Insurance Information: _____

Our office will assist in processing insurance claims. We expect covered patients to read their policies carefully, and to become familiar with benefits and limitations. It is important to understand that dental insurance is designed to reduce cost, not to eliminate it entirely. Please note that pre-authorization estimates of insurance benefits are estimates only. Dealing with insurance companies has become a very time-consuming process. Our office is not responsible for insurance policy determinations or coverage decisions. Regardless of any such determination or decision rendered by the insurer, you remain financially responsible for your dental care.

We will process your insurance claim electronically at the time of service. You will be responsible for what your insurance company does not cover. If your insurance company pays you directly, you will be responsible for payment at the time of service. Co-pay is expected at the time of service. If it is not known at the time of your appointment, a bill will be sent to you for the remaining balance. All payments must be made within 15 days from the date of billing. Unless prior arrangements have been made, accounts unpaid after 15 days from the date of billing are subject to a finance charge of 1.5% per month (18% per Amum). If your account is referred for collection, you will be responsible for court costs and attorney fees.

I have read and understand the above statements and have had ample opportunity to discuss any of this information with Dr. Cummings and/or members of his staff. I accept the above terms.

Date: _____ Signature: _____

Written Financial Policy

Thank you for choosing William N. Cummings, DMD, PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, American Express, or Discover Card

- Convenient Monthly Payment Plans[1] from CareCredit.
    - Allow you to pay overtime
    - No annual fees and long-term options

Please note:

William N. Cummings, DMD, PC requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $1000 or more, a 20% deposit is required to secure your initial treatment appointment.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment[2].

A fee of $50 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.

William N. Cummings, DMD, PC charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent, or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Oral Cancer Screenings Consent Form

Our office is very concerned about oral cancer, and has been conducting visual screenings on every patient.

Traditionally, dentists and hygienists have done oral cancer screening with the naked eye, but recent new technology, the VELscope, has received FDA approval. The VELscope (Visually Enhanced Lesion Scope) will pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns. Suspicious areas can't be seen with the naked eye till stage 3 or 4. With VELscope abnormal tissue can be detected at the earliest stage.

VELscope, similar to other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the VELscope handpiece and the hygienist or dentist may find tissue abnormalities at an earlier stage. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

***36,000 individuals are newly diagnosed with oral cancer each year**

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 65 and older with lifestyle risk factors

Patients with a history of oral cancer

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

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. However, the VELscope exam may or may not be covered by dental insurances. The fee for this enhanced examination is $25. We feel this breakthrough technology is very important to the enhanced quality of care we can offer to our patients. 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.

☐ Yes, I authorize the office to perform the VELscope examination

☐ No, I prefer not to have the VELscope examination done at this time

Patient Name:_____

Signature:_____ Date:_____

ANATOMY CHECKLIST

LIPS
_____Upper
_____Lower
_____Vermillion Border
_____Commisures

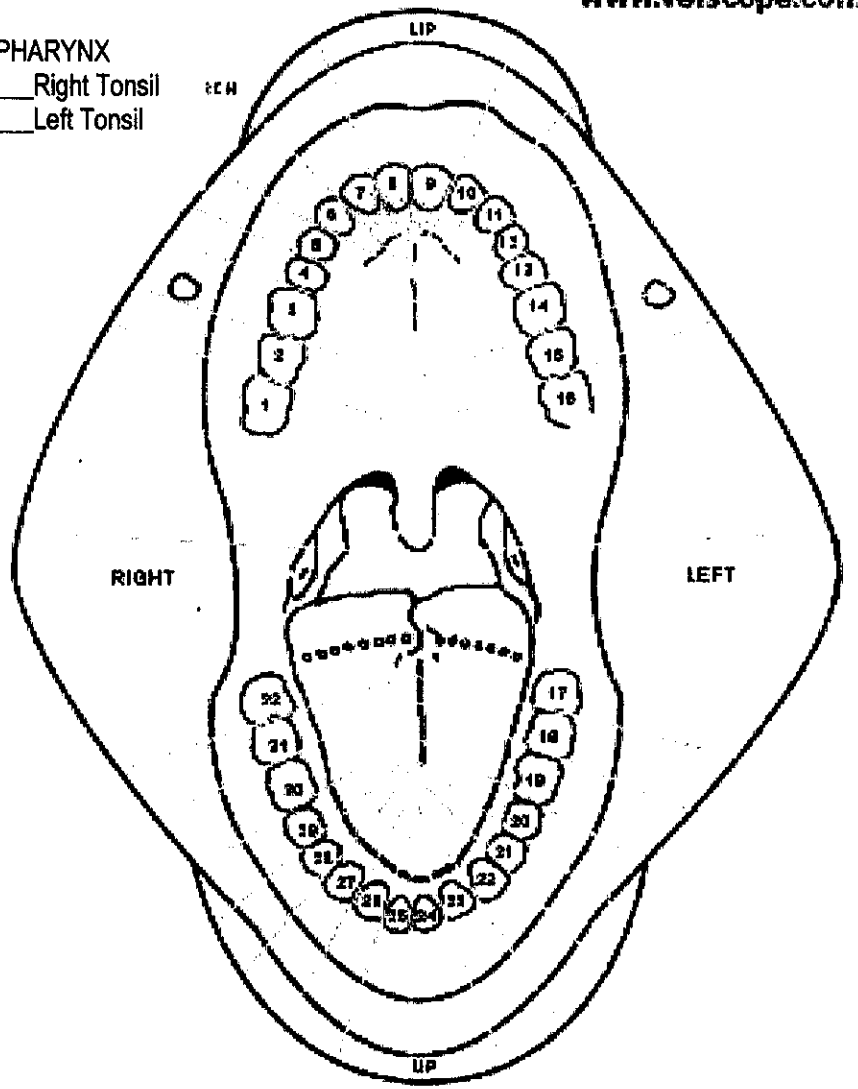
FAUCIAL PILLARS
_____Right Posterior
_____Right Anterior
_____Left Posterior
_____Left Anterior

Patient Name _____ Date _____

CHEEKS
_____Right
_____Left

VELscope
THE ORAL EXAMINATION SYSTEM
www.velscope.com

OROPHARYNX
_____Right Tonsil
_____Left Tonsil

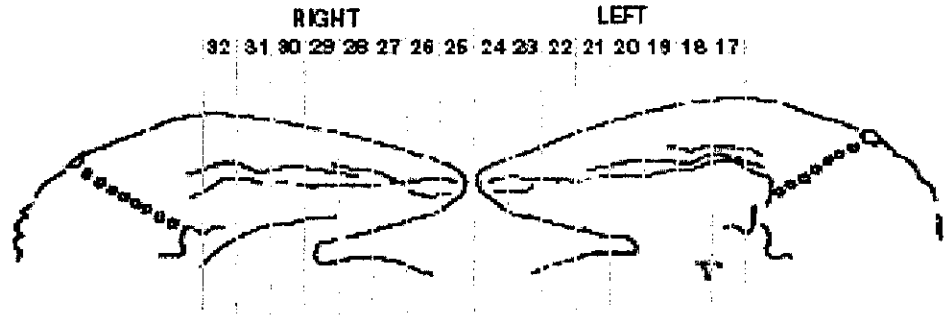


Clinical Impression: _____

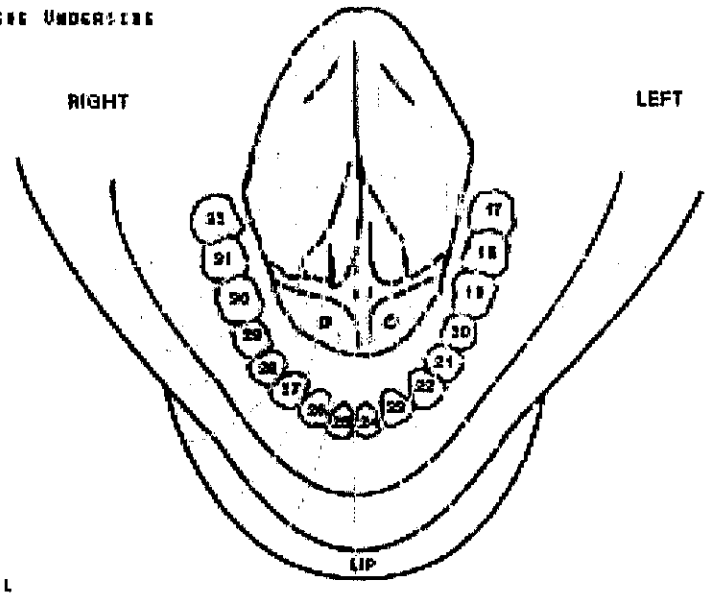
PALATE
_____Uvula
_____Soft
_____Hard

TONGUE
_____Dorsum
_____Right Lateral Border
_____Left Lateral Border
_____Ventral

FLOOR
_____Wharton's Duct



Form C: Tongue Undersides



Clinical Impression: _____