James L. Davenport II, DDS

Patient Information

Thank you for choosing our practice for you dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help you.

Name _____ Birth _____ Social Security # _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email _____

Your (or parent's) Employer _____

Spouse/Parents' Name _____ Phone _____

Whom may we thank for referring you to us? _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of the person responsible for this account? _____

Relationship to patient _____ Phone _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Birth Date _____

Responsible Party's Employer _____ Phone _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____ Ins. Co. _____

Group # _____ Patient's ID # _____

Do You Have Additional Insurance? _____. Ins Co. _____. Name of Insured _____

Date of Birth _____ Social Security # _____ Group # _____

Please Check Any of the following conditions that apply to you:

_____ Bad breath	_____ Like Better Smile	_____ Sensitivity to sweet
_____ Bleeding gums	_____ Like straighter teeth	_____ Sensitivity when biting
_____ Clicking or popping jaw	_____ Like whiter teeth	_____ Sores/growths in mouth
_____ Food collection between teeth	_____ Loose teeth or broken filling	_____ TMJ Disorder
_____ Grinding teeth	_____ Sensitivity to hot/cold	

Medical History

Physician: _____

List all medications you are taking: _____

Allergies: _____

Are you pregnant?_____ Yes ____ No Taking birth control pills? _____ Yes _____ No

Do you have a history of the following?

__ Anemia	__ Cancer	__ Epilepsy	__ Kidney Disease
__ Arthritis	__ Chemical Dependency	__ Heart Murmur	__ Liver Disease
__ Artificial Heart Valves	__ Chemotherapy	__ Heart Surgery*	__ Radiation Treatment
__ Artificial Joints	__ Circulatory Problems	__ Hemophilia	__ Shortness of Breath
__ Blood Disease	__ Cortisone Treatments	__ Hepatitis	__ Stroke
__ Bone Diseases	__ Diabetes	__ High Blood Pressure	__ Tobacco Habit
__ Bone Strengtheners	__ Endocarditics	__ HIV Positive	__ Ulcer

*Heart Surgery Describe _____

Any additional conditions and/or treatments not previously indicated: _____

_____

_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis, and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If my account becomes delinquent I am responsible for all banking and legal fees including a 50% collection fee.

X _____

Signature of Patient (or Parent, if a minor) **Date**

HEALTH HISTORY REVIEWED	_____ Patient Initial	_____ Date	_____ Doctors Initial
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James L. Davenport I I , DDS
5501 N. Oracle Rd,
Suite 141
Tucson, AZ 85704

1.) I understand that Dr. Davenport's front office is happy to file any claims with my designated insurance company, but that final responsibility for payment on all unpaid claims is my responsibility. I also understand that I am responsible for all co-payments and estimated amount on the date the treatment is rendered.

2.) I understand that there will be a minimum charge of $50.00 for any appointment missed or not canceled within at least 48 hours notice (working days notice not the weekend) and this fee could increase according to the time allotted for the appointment in question.

3.) I understand that should I request duplication of my dental records, there is a charge of $35.00 for each record requested and that fee must be paid prior to receiving the records.

4.) I understand that, should my account fall into delinquent status (60 days or more past due) I am responsible for any and all collection and legal fees incurred in the collection process.

5.) I am also aware that, if I elect to pay by check and the check is returned for non-sufficient funds, my check will not be resubmitted for payment I will have to pay all bank fees and the amount of the check in cash or money order

I have read and understand that the above list of office policies. By my signature, I agree to the terms of the information listed above.

Patient/Guardian Signature_____Date_____

Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certfications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that the dental office of Dr. James L. Davenport II has the right to change its *Notice or Privacy Practices* from time to time and that I may contact the office at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name _____ Date _____

Signature _____

Relationship to patient _____

Documentation of denial to sign

_____

_____

DOE ORAL CANCER SCREENING CONSENT FORM

Recent evidence suggest that oral cancer is on the rise and we want to take a more active role in increasing your awareness of the importance of oral cancer screening as well as provide the best possible care to our patients. With 36,000 Americans diagnosed yearly with oral cancer the dental office can be the first line of defense against cancer. There is a 90% chance of survival rate when detected early. We are seeing an increase in the HPV virus especially in the younger population so oral cancer screening is becoming more crucial everyday. Oral cancer has the worst 5 year survival rate of any cancer but if it is recognized early, then the chance of a cure/survival is good. Late detection is one of the primary causes of increased mortality rates from oral cancer.

Risk factors - but not limited to the following:

- Age – age 40 and older
- Tobacco Use
- Drinking alcoholic beverages
- Oral HPV Virus – increasing in young adults

Even though you may not have any of the risk factors above, you are still at risk. CDC recommends an annual oral cancer screening exam. Any delay could put you at risk of oral cancer not being detected at an early stage as oral cancer is often painless in the early stages.

With the advent of technology, we now have better tools to help spot cancer in its early stages. We have incorporated the Dental Oral Exam system into our practice to provide better care to our patients. This system helps the doctor possibly identify an abnormality at an early stage. This is a painless exam that will take approximately 1-2 minutes. The American Dental Association provides a procedure code for the examination and we will make every effort to maximize your insurance and to get coverage for the procedure; however please note that your insurance company may not cover this procedure. The fee for this procedure is _____.

I have read the above statements and have received a copy of them if requested, and recognize their importance in helping me make a decision. My signature indicates that I have read and understand this consent document. The risk and benefits have been explained to me as well as the financial obligation. I have been given ample opportunity to ask questions. I understand that this is a screening tool and not a definitive diagnostic tool and no guarantees have been made to me.

I authorize the above exam and understand my financial responsibility.

Signature: _____ Date: _____

I decline to authorize the above exam and understand the risks of my decision.

Signature: _____ Date: _____