

RANE'S EXCLUSIVELY YOURS DENTAL

A Dental Boutique Just For You!

ALL PHASES OF DENTISTRY ON SITE

Children • Adults • Seniors

609-275-1777

www.ranesdental.com

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

Another patient, friend

Name : _____

Another patient, relative

Name: _____

Sign

Yellow Pages

US 1Newspaper

South Brunswick Post / Cranbury News

Mailing

Insurance

Plainsboro Plaza (Superfresh)

Work

Walk In

Other _____

Name Of person or office referring you to our practice: _____

Your Email:

(Used only for practice information and oral health updates, we do not give out emails to outside parties)

Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
E-mail address _____ Gender: _____ Family Status: _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____
Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S
Address: _____
Street Apartment #
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems | |
| | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems | |

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____
Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street _____ City, State Zip Code _____ Phone _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

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HIPPA CONSENT

I give this practice /clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used or disclosed.

I also understand that 48-Hours cancellation notice is required on any appointments or I will be responsible for a broken appointment fee.

Signature: _____

Date: _____

Patient, parent or legal guardian

If signed by patient representative, stat relationship to patient: _____

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PATIENT FINANCIAL AGREEMENT

200 % Customer Satisfaction Is The Goal At Rane's Exclusively Yours Dental!

“To provide exclusive dental care by the best team of healthcare advisors, creating lasting relationships with you and your referrals and ultimately providing you 200% satisfaction.”

Motto: A home for all phases of dentistry serving you with compassion.

Your treatment plan fees are an **ESTIMATE ONLY** based on the information you or your insurance company has provided us with. The insurance company does not guarantee payment. The guarantor is the account holder and responsible for the patient account. We respect and honor all our patient's time with us so as a professional courtesy we call to confirm your appointment several days in advance. It is also important for you to reply with a confirmation so that others in need of surgery time or serious dental attention can be offered that time slot (*as we would do for you*). For us to provide you with prompt appointments and quality care we need your cooperation with the schedule. Our office financial agreement is as follows:

I acknowledge that this is an estimate only and my co-payment is due on the date of service. I also understand that I, not the insurance company, am ultimately responsible for payment in full for all service rendered.

I fully agree that if my account is past due 30 days (after the time period for collection of insurances) the office may refer to an outside agency for collection. I also understand that a reasonable collection fee of \$75.00 or 20% of the balance owed which ever is higher will be added to my total charges. (These collection fees are customary standard amounts used by professional services as means of collection.)

I fully understand that when an appointment is made on my request I must confirm my appointment or give Rane's Dental Offices a 48 hour notice to cancel the appointment. I agree if I do not confirm my appointment and it is one day prior to my scheduled date the office has my permission to give the time slot to another patient. I may also be charged a \$75 cancellation fee (\$125 for surgeries and specialty work) depending on the reason for cancellation at the office discretion. This fee is usually waived for a genuine excuse but is exercised mainly for habitual appointment breakers.

To keep your treatment fees affordable we offer you a 90 day case acceptance. Product prices change regularly and we can only guarantee pricing for the time specified. We can offer you affordable monthly payments through our finance agency with a possible 18mo. Interest free plan. Treatment plans paid in full have a higher incentive as a patient appreciation plan. It is necessary for us to present fees to you so you can make good decisions about your health.

Signature: _____

Date: _____

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Oral Cancer Screening Consent Form

Early Detection Is The Key To Saving Lives

Our practice continually seeks advances to ensure that we are providing the optimum level of oral healthcare to our patients. We are concerned about oral cancer and screen every patient.

One person in America dies from oral cancer every hour. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase.

As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but more than 25% of oral cancer victims have no such lifestyle risk factors. Oral cancer risk by patient profile is as follows:

- Increased risk:** Patients ages 18-39 (sexually active patients; Human Papilloma Virus/16-18).
High risk: Patients age 40 and older, tobacco users (any age, within 10 years).
Highest risk: Patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer.

We have recently incorporated **VELscope** into our oral screening standard of care. We find that using VELscope for an oral cancer examination improves the ability to identify suspicious areas at their earliest stages. **VELscope is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA and is recommended once a year by the American Cancer Society.** VELscope is a simple and painless examination that gives the best chance to find any oral abnormalities at their earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life.

The VELscope exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this examination is \$35 and is due at the time of service.

This exam is highly recommended by all our doctors.

Dr. Janhavi Rane, DDS

Dr. Pradeep Sukumar, DMD, MPH

Dr. Hyeshek Lee, DDS

Below listed are the leading risk factors associated with oral cancer. Please check if any of the following apply to you:

_____ Use of Tobacco Products _____ Family Members Have Had Cancer
_____ Drink Alcohol _____ Over Age 40

____ **YES.** I authorize the clinician to perform the VELscope exam along with the standard oral cancer Examination and assume total financial responsibility for it.

____ **NO.** I decline the VELscope exam at this time.

Patient Name: _____ Signature: _____ Date: _____