RANE'S EXCLUSIVELY YOURS DENTAL

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 of the person referring) _____

Referred by a Family member (Family member's name)_____

- Sign
- Yellow Pages
- Newspaper
- Mailing
- Insurance
- Work (name of colleague referring) _____
- Walk In
- Rane's Dental website
- Google/Internet
- Other _____

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)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

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

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:

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

OTHER:

- ☐ _____
- ☐ _____

- 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:_____

Are you currently taking any medication or taken within the past one year: Yes No
If you have marked YES what medications are you taking:

_____

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.

_____ Date: _____
Signature of patient, parent or guardian

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
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

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
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

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: PLEASE READ CAREFULLY

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. Please call your insurance company prior to your visit for any copays or clarifications.

A service charge of 1½% 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 ONLY** listed for this dental care can only be extended for a period of **THIRTY DAYS** 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.

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

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

HIPAA 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.

Please Note: If I request release of my records electronically the office uses AOL e-mail services.

Signature:_____ Date:_____
Patient, parent or legal guardian
*If signed by patient representative, stat relationship to patient:*_____

Please list name and relationship with only whom we may disclose your complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions?

Name: _____ Relationship_____ Cell#_____

Name: _____ Relationship_____ Cell#_____

I understand that the person(s)/organization(s) listed may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ I understand the above information and agree with its contents, and this will serve as the HIPAA Disclosure Form.

Patient or Guardian Signature _____

Date_____

RANE'S EXCLUSIVELY YOURS DENTAL
RANE'S DENTAL AESTHETICS

OUR VALUED PATIENT AGREEMENT

PLEASE READ BEFORE SIGNING THIS DOCUMENT

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

Our Mission: "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.

In order for us to accomplish the above goals, we need your commitment and cooperation to the following policies:

1. **Treatment recommendations are based on your health, not on your dental benefits or lack thereof. Your treatment plan fees are an ESTIMATE ONLY based on the information you or your insurance company has provided us. The insurance company does not guarantee payment and you are ultimately responsible for any portion not covered by your plan. If your account is past due 30 days (after the time period for collection of insurances) the office may refer to an outside agency for collection and a reasonable collection fee of $75.00 or 20% of the balance owed whichever is higher will be added to your total charges. (These collection fees are customary standard amounts used by professional services as means of collection.)**

2. **It is critical to maintain your recommended dental schedule in order to avoid setbacks in the care of your teeth and gums. Missed appointments and failure to comply with recommended treatment schedules prevents us from achieving the goal of your optimal health. A broken appointment also prevents other patients from receiving necessary care and increases the cost of delivering care for everyone. We ask that you make every effort to be on time for an appointment and not to change or break a reserved appointment. If you must change or cancel, we ask that you give us at least 48 hours' notice or you will be charged a $75 fee for the broken or missed appointment ($125 for surgeries and specialty work) which is not an insurance covered expense. This fee is generally waived for a genuine excuse but will be charged for habitual appointment breakers.**

3. **To keep your treatment fees affordable we offer you a 30 day case acceptance. Material prices change regularly and we can only guarantee pricing for the time specified. It is necessary for us to present fees to you so you can make good decisions about your health. However we do like to run a zero balance office and expect patient portion payment in full prior to or at time treatment is provided. We can offer you affordable monthly payments through our finance agency with up to an 18mo. interest free plan. Prepaid treatment plans in full have a higher incentive as a patient appreciation plan.**

Most Sincerely Yours,
Rane's Dental Team

Signature:_____

Date:_____

RANE'S EXCLUSIVELY YOURS DENTAL

All Phases Of Dentistry On Site

CHILDREN – ADULTS – SENIORS

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. Anagha Padmawar, DDS
Dr. Hyeshik 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: _____

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We feel that every patient in our practice deserves to have a smile they can be proud of. We are excited to offer our patients a unique program we call Whitening for Life.

When you come to our office for your preventive examination, x-rays and cleaning, we will provide you with custom bleaching trays and materials for a one-time enrollment fee of $199. Then, at each 6 months recommended preventive visit, we will give you one complimentary touch up whitening syringe. Any default on the 6 months clause will incur $25 fee for the whitening syringe. This ensures that you will be able to keep your teeth bright and beautiful for life!

All we ask in return is:

- Y**ou keep your six month preventive visits current**. Your long term dental health is as important to us as it is to you. Our patients have found that these six month visits help greatly reduce emergencies. That is why we are happy to provide this extra bonus for our patients who are committed to their dental health.
- **Provide at least 48 hours notice** if you need to cancel or change an appointment. In order to provide exceptional services like Whitening for Life to all of our patients, we ask that you give us the courtesy of advance notice for schedule changes.

We appreciate the opportunity to serve you, and look forward to seeing your bright smile for many years to come!

I understand the Whitening for Life program requirements, and would like to enroll

Name:_____

Signed:_____

Date:_____

*** Your Whitening for Life membership is valid as long as Dr. Rane retains her private practice in dentistry.**