Ascension

PREMIER DENTAL

Patient Credit Check Authorization Form:

Dr. Calvin G. Bessonet III and staff would like to Thank You for choosing our office and we appreciate your business greatly. As a courtesy to our patients we have decided to offer some In-House Financing Options

Please Sign whichever option best suits your financial needs

I, _____, give Ascension Premier Dental, Calvin G. Bessonet III, DDS, FAGD and staff permission to do a Health Credit Inquiry in order to set an Easy Pay Credit Card Payment Plan with our office. This is just a soft inquiry and will not affect your credit rating.

I, _____, **do not** give Ascension Premier Dental, Calvin G. Bessonet III, DDS, FAGD and staff permission to do a Health Credit Inquiry in order to set up an Easy Pay Credit Card Payment Plan with our office. I acknowledge that denying this credit inquiry also includes my option of setting up an Easy Pay Credit Card Plan as well.

By denying my credit inquiry, I acknowledge my payment for service will be due in full when my services are rendered.

Again, Thank You for choosing Ascension Premier Dental and if you have any questions, comments or concerns please let us know. We would love to hear your feedback on the new services we are offering.

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PREMIER DENTAL

Patient Information

Name_____
Last First Middle Initial Preferred Name

Address_____
Street

_____
City State Zip Code

Employer_____Military ID_____

Birth Date_____ Social Security #_____

Work:(_____)_____ May we contact you at work? ( )Yes ( )No

Mobile:(_____)_____ ( ) Male ( ) Female

( ) Married ( ) Single ( ) Dependant/Child

Email address: _____

Please circle your preferred contact method for appointment confirmations: Phone call or Text

Emergency Name and Phone _____ (____)_____

Relationship to Patient_____

How did you hear about us? Please circle one: Mailer Sign/Drive by Internet/Google Newspaper Radio Insurance Co. Facebook Word of mouth Email Other _____

I understand that I am responsible for all costs for dental treatment. I hereby authorize Ascension Premier Dental to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

_____ _____
Signature of Patient/Guardian Date

Other Information

What is the reason for today's visit? _____

Would you be interested in the use of Nitrous Oxide to make your visits easier? _____

Why did you leave your last dentist? _____

What did you like most about your last dentist? _____

When was your last dental cleaning? _____ When was your last dental x-ray? _____

When was your last dental visit? _____

Do you love your smile? _____

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PREMIER DENTAL

Medical History and Information

Your current health is: ( ) Good ( ) Fair ( ) Poor
Are you currently in pain? ( ) Yes ( ) No
Have you ever had gum treatment? ( ) Yes ( ) No

How many times do you: floss/Week? _____ brush/day? _____
Are your teeth sensitive to hot, cold or anything else? ( ) Yes ( ) No
Do you take any bone density medications? ( ) Yes ( ) No

Conditions

Please check all that apply:

( ) Abnormal Bleeding
( ) Alcohol Abuse
( ) Allergies
( ) Anemia
( ) Angina Pectoris
( ) Arthritis
( ) Artificial Heart Valve
( ) Asthma
( ) Blood Transfusion
( ) Cancer
( ) Chemotherapy
( ) Colitis
( ) Congenital Heart Defect
( ) Diabetes
( ) Difficulty Breathing
( ) Drug abuse
( ) Emphysema
( ) Epilepsy
( ) Facial Surgery
( ) Facial Trauma
( ) Fainting Spells
( ) Fever Blisters
( ) Frequent Headaches
( ) Glaucoma
( ) HIV+/ AIDS
( ) Heart Attack
( ) Heart Surgery
( ) Heart Murmur
( ) Hemophilia
( ) Hepatitis A
( ) Hepatitis B
( ) Hepatitis C
( ) High Blood Pressure
( ) Joint Replacement
( ) Kidney Problems
( ) Liver Disease
( ) Low Blood Pressure
( ) Mitral Valve Prolapse
( ) Pace Maker
( ) Psychiatric Problems
( ) Radiation Therapy
( ) Rheumatic Fever
( ) Seizures
( ) STD's
( ) Shingles
( ) Sickle Cell Disease
( ) Sinus Problems
( ) Stroke
( ) TMJ Disorders
( ) TMJ Pain
( ) TMJ Clicking/Popping
( ) Thyroid Problems
( ) Tuberculosis
( ) Ulcers
( ) Vertigo

Allergies

( ) Aspirin
( ) Codeine
( ) Sedatives
( ) Dental Anesthetics
( ) Erythromycin
( ) Latex
( ) Metals
( ) Penicillin
( ) Sulfa
( ) Tetracycline

Other Allergy _____

Do you smoke? ( ) Yes ( ) No
Do you use tobacco? ( ) Yes ( ) No
Do you usually pre-med before your dental visit's? ( ) Yes ( ) No

If Female:
Are you pregnant? ( ) Yes ( ) No
Are you Nursing? ( ) Yes ( ) No

Do you suffer from any other conditions/ disorders that are not listed above? _____

Please list any medications that you are currently taking: _____

I attest that the information given is true and accurate to the best of my knowledge.

_____ _____
Signature Date

I understand that I am responsible for all costs for dental treatment. I hereby authorize Ascension Premier Dental to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

_____ _____
Signature of Patient/Guardian Date

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PREMIER DENTAL

Adjunctive Oral Cancer Screening Acceptance Form

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 a primary reason 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 65 and older with lifestyle risk factors
- - Patients with history of oral cancer

25% of oral cancers occur in people who do not smoke and have no other risk factors.

We find that using VixiLite Plus along with a visual oral cancer examination improved 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 **DOES NOT** cover the Vizilite Plus exam. The fee for this enhanced examination is **$78.00**

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for the enhancement examination.

Print Name: _____

Signature: _____ Date_____

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

Print Name: _____

Signature: _____ Date_____

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Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessarily advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. ***Payment for all treatment and services rendered are my responsibility.***

_____ _____

Patient/Guardian Signature Date

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PREMIER DENTAL

At ***Ascension Premier Dental***, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we will provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know……

Your dental benefits are based upon a contract made between your employer and an insurance company. ***If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care.*** It is only meant to assist you.

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at time of service. We estimate your portion based on the most up-to-date information we have, but it is ***ONLY AN ESTIMATE.*** If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. **Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."**

We bill your insurance as a courtesy. If insurance does not pay within 90 days, Ascension Premier Dental reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that contract. Ultimately, you are responsible for all charges incurred in our office.

Ascension Premier Dental does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, Amex, cash, and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with Care Credit, who offers a six month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. We also offer other patient financing options through Green Sky with approved credit.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hour notice to avoid a $100/hour cancellation fee **(EMERGENCIES ARE AN EXCEPTION).** ***To reserve an appointment longer than 1 hour your portion will be required at the time of scheduling. If an appointment is not cancelled within 48 hours of the appointment time your deposit will not be refunded. This policy helps us to keep our appointments available for everyone's convenience.***

After Hours/ Weekend Emergencies**:** In the event of an emergency after regular business hours a ***$55*** emergency fee will be charged for established patients in addition to necessary treatment fees. Patients who are not established in the practice will be charged ***$125 after hours emergency fee.***

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Print: _____ **Sign: _____**

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PREMIER DENTAL

Dear patients,

*At **Ascension Premier Dental**, we pride ourselves on quality care and service. We assure the best possible treatment to each and every patient that walks through our door. Dr. Bessonet spends as much quality time as the patient needs and provides exceptional dentistry to every patient he treats. Ascension Premier Dental is not only convenient in location but we are also very flexible with scheduling including emergency visits. We believe in giving every one of our patients the best treatment possible.*

***Ascension Premier Dental** is a dental provider and we accept and file all PPO and regular insurance. Unfortunately, we do not honor HMO's or discounted fee schedules. **We file your dental insurance as a courtesy but it is the patients' responsibility to know what their particular plan entails.** A patient should know when their policy was activated, what percentage they are responsible for paying and when they are eligible for x-rays and/or all other dental related treatment. By choosing Ascension Premier Dental, as your dental provider, you can trust that we will take care of each patient like we would our own family*

***Footnote**: We always have each patients' benefits verified via phone or fax but we do not check eligibility unless otherwise asked by the patient. If you would like for us to check your eligibility for you at the time of your appointment, we will do so as a courtesy to our patients.*

_____ _____

Patient Signature Date

Ascension

PREMIER DENTAL

Dental Prosthesis Disclaimer

In the event of a patient needing any dental prosthesis' custom ordered from a laboratory, the patient's responsibilities are as follows:

- the patient is responsible for returning back to the office within 4 weeks from the date of his/her initial appointment when the impressions were taken. If the crown, bridge or denture comes in but the patient does not return within the 4 weeks allowed and the prosthesis **does not fit,** the patient will be responsible for the cost to remake the prosthesis. **The patient is also responsible the remainder of the payment of any work we have done even if final product is not delivered.**

If the patient returns to the office, within the time allowed and the prosthesis **does not fit**, Ascension Premier Dental, will be responsible for any costs to remake that prosthesis.

_____

(Patient's signature)

_____

(Date)

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PREMIER DENTAL

Photography Release

I, _____
hereby authorize Ascension Premier Dental, LLC and/or associates or staff members to take photographs, slides and/or videos of my face, jaws and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my treatment and may be used for educational purposes in lectures, demonstrations, advertising (including website publication) and professional publications (dental magazines and journals).

I further understand that if the photographs, slides and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature of Patient/Legal Guardian_____

Date _____

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PREMIER DENTAL

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights 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 certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization had the right to chance its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above 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 our treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions

Patient Name: _____

Relationship to Patient _____
(If patient is minor)

Signature _____

Date _____

Please list any individual(s) that you give permission to have access to records (medical and financial)

_____

_____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below:

Date_____Initials_____Reason_____