Eva L. Jessup, D.D.S.
2221 Clearview Parkway, Suite 202
Metairie, LA 70001

Telephone: (504) 455-1667

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date_____ Home Phone(___)_____

Name_____ Soc. Sec. #_____

Last First Initial

Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐Single ☐Married ☐ Widowed ☐ Divorced

Drivers License #_____ Email_____

Cell Phone # (___)_____ Pager Phone # (___)_____

Patient Employed by_____ Occupation _____

Business Address_____ Business Phone(___)_____

Whom may we thank for referring you?_____

In case of emergency who should be notified?_____ Phone(___)_____

PERSON RESPONSIBLE FOR ACCOUNT

Home Phone(___)_____

Name_____ Soc. Sec. #_____

Last First Initial

Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐Single ☐Married ☐ Widowed ☐ Divorced

Drivers License #_____ Email_____

Cell Phone # (___)_____ Pager Phone # (___)_____

Patient Employed by_____ Occupation _____

Business Address_____ Business Phone(___)_____

Payment is due in full at time of treatment unless prior arrangements have been approved.

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle

Soc. Sec. #_____ Birth date _____ Relation to Patient _____

Address (if different from patient's)_____ Phone (___)_____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation _____

Insurance Company_____

Subscriber #_____ Group #_____ Contract #_____

Names of other dependents covered under this plan_____

Do you have secondary insurance?_____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Taking birth control pills/Hormone Therapy ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Emphysema
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS/ARC
- ☐ Jaw Pain TMJ/TMD
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

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☐ Chemical Dependency ☐ Heart Problems ☐ Radiation Treatment
☐ Chemotherapy ☐ Hemophilia ☐ Respiratory Disease
☐ Circulatory Problems ☐ Rheumatic Fever

MEDICATIONS

List medications you are currently taking:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ALLERGIES

☐ Penicillin ☐ Local Anesthetic
☐ Codeine ☐ Aspirin
☐ Sulfa ☐ Other: _____
☐ Iodine _____
☐ Latex _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that I am financially responsible for all collection and legal fees associated with my account. All the above information is true to the best of my knowledge.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Clearview Dental Care LLC
Eva L. Jessup DDS

2221 Clearview Pkwy, Ste. 202
Metairie, LA 70001

Acknowledgement of receipt of
NOTICE OF PRIVACY PRACTICES handout

I acknowledge that I have received a **NOTICE OF PRAVICY PRACTICES** handout.

Signature Date

Relationship if other than patient

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

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 the primary reason that 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 age 65 and older with lifestyle risk factors
- Patients with history of oral cancer

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

We find that using ViziLite Plus along with a visual oral cancer examination improves 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 might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is $ 68.00.

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

Print name: _____

Signature: _____ Date: _____

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

Print name: _____

Signature: _____ Date: _____

Dr. Eva Jessup

IMPORTANT INFORMATION FOR OUR PATIENTS

DENTAL INSURANCE...

We are glad to assist you in obtaining the maximum benefit from your dental insurance plan. Once your plan coverage has been verified, we will accept assignment of payment from your insurance company. Most plans cover a portion of the dental fee, which means you will be responsible for your deductible or co-pay and the portion we estimate your plan will cover. Payment of your portion is expected at the time of service.

Please note: Full payment is expected at your first visit if no insurance information is provided to our office.

PAYMENT OPTIONS...

For your convience, we accept major credit cards, cash and personal checks. Outside financial arrangements can be made to assist you with your budget. For any treatment over $1000.00 we offer a courtesy savings of 5% when all fees are paid at the beginning of treatment with cash check or credit card. We also offer outside financing as a payment option. (Please see brochure available)

A fee of $25.00 will be charged for any NSF checks.

APPOINTMENTS...

Our appointments are scheduled to respecf your time. We reserve a specific time for your care and we make every effort to see you at that appointed time. We appreciate your promptness and consideration in not changing your scheduled time. We also understand that circumstances may arise and you might need to change your appointment time.

We respectfully ask that you give us 24 hours notice of cancellation, if we receive notice less than 24 hours before your appointment we shall reserve the right to charge a $25.00 cancellation fee. Prices are subject to change without notice.

We welcome you to our practice and will be happy to answer any questions that you may have.

I hereby authorize that I have read and understand the above information.

_____

Signed by patient Date

NOTICE OF PRIVACY PRACTICES

This Notice Describes How Health Information About You May Be Used And Disclosed And How You Can Get Access To This Information.

Please Review It Carefully. The Privacy Of Your Health Information Is Important To Us.

Our Legal Duty

Federal and State law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provide the law allows us to do so. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. We will change this notice before any new changes are implemented.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. This can include quality assessment and improvement activities, professional reviews, provider performance, training programs, accreditation, certification, licensing and credentialing activities. We may disclose your healthcare information to another health care provider that is subject to the federal privacy rules and that has a relationship with you.

On Your Authorization: You may give us written authorization to use your information or to disclose it to anyone for any purpose. You may revoke this in writing at any time. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family And Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health care information to these people, we will provide you with an opportunity to object or use our disclosure. If you are not present, or in the event of an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders; such as voice mail messages, letters and post cards.

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.