



Stanley M. Prince
Family & Cosmetic Dentistry
124 Andrews Way, Suite A
St. Marys, GA 31558
(912) 882-4274
greatsmiles@tds.net

*Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs,
please fill out this form completely in ink. If you have
any questions or need assistance, please ask us –we will be happy to help.*

Patient Information (Confidential)

Reason for Visit: _____

Name: _____ Birthdate: _____ Date: _____

SSN #: _____ Home Phone: _____ Cell Phone: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address, if Different: _____

City: _____ State: _____ Zip: _____

E-Mail: _____

Check Appropriate Box(s): Minor Single Married Divorced Separated Widowed

If Student, Name of School/College: _____ Full Time Part Time

Patient's Employer _____ Work Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Whom May We Thank for Referring You? _____

Emergency Contact: _____ Phone: _____

Responsibly Party

Responsible Person for Account: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

If Military, Name of Command: _____

Email: _____ Birthdate: _____

Driver's License #: _____ Driver's License State: _____

Is this Person Currently a Patient in Our Office? Yes No

For your convenience, we offer the following methods of payments. Please check one. Payment in full required at each appointment.

Cash Check Credit Card (Visa/MasterCard/Discover) Care Credit I Wish to Discuss the Office's Payment Plan Policy

****Any accounts 30 days past due may incur a finance charge and/or billing charges. If sent to collections, the responsible party, (if patient is a minor) will be responsible for all related fees and court costs. If you have any questions related to your account, please do not hesitate to contact our office.****

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: _____

Insured SSN #: _____ Insured Date of Birth: _____

Insurance Company: _____

Insurance Telephone Number: _____

Subscriber ID Number: _____ Group Number: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: _____

Insured SSN #: _____ Insured Date of Birth: _____

Insurance Company: _____

Insurance Telephone Number: _____

Subscriber ID Number: _____ Group Number: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Authorization and Release

I authorize Stanley M. Prince, DMD to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits to Stanley M. Prince, DMD, otherwise payable to me. I understand that my dental insurance or payer of my dental benefits **may pay less** than the actual bill of services. I understand that **I am financially responsible** for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Signature: _____ Date: _____

Print Name: _____ Relationship: _____

Patient Dental History

Patient Name: _____ Date of Birth: _____

Name of Previous Dentist: _____ Dentist Phone Number: _____

Date of Last Exam: _____ Date of Last Cleaning: _____

	Yes	No
1. Do you have normal regular dental care?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been told you have gum disease?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you feel any pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had any head, neck or jaw joint injuries?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you experienced any of the following problems in your jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>
Pain (Joint, Ear, Side of Face)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
If so, explain: _____		
14. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
If so, explain: _____		
15. Have you had your wisdom teeth removed?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date of placement _____		
17. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have trouble chewing?	<input type="checkbox"/>	<input type="checkbox"/>
20. How often do you brush your teeth? _____		
21. How often do your floss your teeth? _____		
22. Did you ever wear braces?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when: _____ Name of Orthodontist _____		
23. Do you have any questions or concerns you have that you would like to discuss with Dr. Prince?	<input type="checkbox"/>	<input type="checkbox"/>

I understand that these questions were answered truthfully and to the best of my knowledge.

Signature: _____ Print Name: _____ Date: _____

VELscope Oral Cancer Screening Consent Form

Risk Factors of Oral Cancer (Controllable and Uncontrollable)

- Tobacco use
- Excessive alcohol consumption
- Using both tobacco and alcohol
- Excessive unprotected sun exposure
- Low intake of fruits and vegetables
- HPV viral infection
- Race, ethnicity, and economics
- High risk of cancer recurrence
- Gender and age

Signs and Symptoms

Early Indicators

- Red and/or white discolorations of the soft tissues of the mouth
- Any sore which does not heal within 14 days
- Hoarseness which last for a prolonged period of time

Advanced Indicators

- A sensation that something is stuck in your throat
- Numbness in the oral region
- Difficulty in moving the jaw or tongue
- Ear pain which occurs on one side only
- A sore under a denture that won't heal, even after adjustment of denture
- A lump or thickening which develops in the mouth or neck

Oral Cancer statistics

Each year in the US alone, approximately 34,000 individuals are newly diagnosed with oral cancer. The death rate from oral cancer is very high; about half of those diagnosed will not survive more than 5 years. With early detection, survival rates are high, and the side effects from treatment are at the lowest.

Our practice believes in early detection of oral cancer. We can now offer you a state-of-the-art cancer exam called the VELscope Oral Cancer Screening System. As always, we will continue to provide conventional oral cancer screening exams, however now we are able to do even more!

About the VELscope exam:

- The exam takes approximately 3-5 minutes
- The exam is comfortable and pain-free
- Completely safe to perform

Patient signature: _____ **Print name:** _____ **Date:** _____

The VELscope peace-of-mind evaluation is available for a one time fee of \$26.00. This may not be covered by your insurance.

_____ Yes, I authorize Dr. Prince or the hygienist to perform the VELscope Oral Cancer Screening Exam and accept the financial responsibility for this procedure

_____ No, I would prefer not to have the VELscope Oral Cancer Screening Exam at this time.

Patient Medical History

Patient Name: _____ Date of Birth: _____

Name of Physician: _____ Physician Phone Number: _____

Pharmacy: _____ Are you seeing a physician for anything other than regular checkups? Yes No

If yes, why: _____ Last visit: _____

Women Only: Are you pregnant? Yes No If yes, due date: _____ Are you nursing? Yes No

Are you allergic to any of the following? Check all that applies.

Latex Penicillin or Other Antibiotics Local Anesthetics Codeine or Other Narcotics Sulfa Drugs

Other: _____

Please answer the following questions

	Yes	No		Yes	No
ADD	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: Type _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/STD	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	HPV Vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Abnormally	<input type="checkbox"/>	<input type="checkbox"/>	Low Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
COVID-19	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes: _____	<input type="checkbox"/>	<input type="checkbox"/>	Smoker/Dipper	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Feet/Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems: High or Low	<input type="checkbox"/>	<input type="checkbox"/>
Headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Tumor/Growth on Head/Neck	<input type="checkbox"/>	<input type="checkbox"/>

Other health problems not mentioned above: _____

I understand that these questions were answered truthfully and to the best of my knowledge.

Signature: _____ Print Name: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been notified of this office's Notice of Privacy Practices (HIPAA).

HIPAA policies are posted at the reception counter. I understand that I may receive a written copy of the HIPAA practices upon my asking.

I give Dr. Prince and his staff permission to discuss my protected health information to the following people:

(1) Name: _____ Relation: _____
Home Number: _____ Cell Number: _____

(2) Name: _____ Relation: _____
Home Number: _____ Cell Number: _____

(3) Name: _____ Relation: _____
Home Number: _____ Cell Number: _____

_____ Please check if you do not want Dr. Prince or his staff to discuss your protected health information with anyone.

Print name: _____

Signature: _____ Date: _____

Terms for Deposit on Dental Treatment

When you have been scheduled for dental treatment, we will require a 25% deposit of the treatment fee (totaling \$500 and above OR any scaling and root planing treatment) to reserve the chair time. It is important that you read and understand the terms of placing a deposit on your account.

A deposit is also mandatory for all appointments that involve any dental treatment that requires outside laboratory work, major dental treatment, and lengthy appointment times or in situations of scheduling difficulties.

The deposit will be posted to your account the day the appointment is reserved (Appointments need to be made no further than 2 weeks after deposit is placed). Please note that a deposit is not refundable, unless you give a 72 business hour notice prior to your scheduled appointment (Remember, our office is closed on Fridays).

If you fail to give adequate notice, the deposit will remain on the account until you either schedule the appointment, or it can be used for other dental care that does not require a deposit. If you decide, more than 72 business hours before the scheduled appointment, that you wish to have a refund, we will be happy to issue a refund in full, less any credit card charges if they apply. All checks must have cleared the bank prior to a refund. In the event that you should miss a second reserved appointment time, your deposit will be used to cover the lost chair time.

PAYMENT POLICY: In compliance with the Truth in Lending Law, here is our credit policy: It is customary to pay fees at the time services are rendered unless other arrangements have been made. To assist you with this, we will accept cash, check, and most credit cards. On reconstruction cases (crown, bridge, and partial and full dentures) 50% of the fee is due at the first appointment and balance due at the time of insertion. If you have dental insurance, we will accept assignments on that portion of your charges which are covered by insurance. However it must be understood that you will be responsible for immediate payment of any deductible amount and co-payment not covered by insurance; in addition, you will be responsible for any portion of the assigned amount not paid by your insurance company within 60 days.

If you have any questions about the above terms, please ask before scheduling treatment.

Patient: _____

Date: _____

Signature: _____



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Appointment Guidelines

We are committed to the highest quality of care for all our patients; therefore we schedule all appointments in advance and make every attempt to confirm with you two or more days (48 business hours for our office). When we schedule your dental visit, that time is reserved exclusively for us to take care of your dental needs.

Our normal business hours are as follows:

Monday: 8:10 am – 6:00 pm (Lunch from 12:00 pm – 1:00 pm)
Tuesday: 8:10 am – 5:00 pm
Wednesday: 8:10 am – 5:00 pm
Thursday: 7:00 am – 2:00 pm
Friday-Sunday: Closed

Multiple Family Members – We are only able to book 2 family members at a time for ANY appointment until each family member has become established with our office. If for any reason, you fail to keep a scheduled multifamily appointment, we may not be able to honor this benefit again.

Long appointment times and/or major dental procedures require a deposit no matter what the appointment history is. (Please see “Terms of Deposit” for more information).

Appointment Cancellation – We understand that non-preventable occurrences can come up that may require you to cancel and reschedule your appointment with our office. We ask that you please give us a 48 business hours’ notice so that we have time to fill your reserved chair time. If you fail to give us a 48 business hour notice, and the missed appointment is not an emergency, we will consider this a broken appointment.

Our Broken Appointment Policy is as follows:

1st Broken Appointment – \$35.00 Fee or warning (office discretion)
2nd Broken Appointment - \$35.00 Fee or 25% of Appointment (Whichever is Greater)
3rd Broken Appointment – Up to 100% of appointment fee & Pre-Pay for Your Next Visit in Full
4th Broken Appointment – Possible dismissal from office

***If the same appointment is broken back to back, the patient is responsible for the FULL fee.

Please sign below stating that you have read and understand the above information.

Patient Signature

Date

Printed Patient Name

Stanley M. Prince D.M.D., PC

124 Andrews Way, Suite A

St. Mary's, GA 31558

Office Phone: (912) 882-4274

Office Fax: (912) 673-1311

E-Mail: greatsmiles1234@gmail.com

Re: Dental Records Release

Patient's Name(s): _____

Date of Request: _____

I give the office of _____ permission to forward a copy of my records to the office of Stanley M. Prince D.M.D.

Signed: _____

Relationship (if not patient): _____