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?	☐	☐
2.	Have you ever been told you have gum disease?	☐	☐
3.	Do your gums bleed while brushing or flossing?	☐	☐
4.	Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
5.	Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
6.	Do you feel any pain to any of your teeth?	☐	☐
7.	Do you have any sores or lumps in or near your mouth?	☐	☐
8.	Have you had any head, neck or jaw joint injuries?	☐	☐
9.	Have you experienced any of the following problems in your jaw?	☐	☐
	Clicking	☐	☐
	Pain (Joint, Ear, Side of Face)	☐	☐
	Difficulty in opening or closing	☐	☐
	Difficulty in chewing	☐	☐
10.	Do you have frequent headaches?	☐	☐
11.	Do you clench or grind your teeth?	☐	☐
12.	Do you bite your lips or cheeks frequently?	☐	☐
13.	Have you ever had any difficult extractions in the past?	☐	☐
	If so, explain: ______________________________		
14.	Have you ever had any prolonged bleeding following extractions?	☐	☐
	If so, explain: ______________________________		
15.	Have you had your wisdom teeth removed?	☐	☐
16.	Do you wear dentures or partials?	☐	☐
	If yes, date of placement ____________________		
17.	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
18.	Do you like your smile?	☐	☐
19.	Do you have trouble chewing?	☐	☐
20.	How often do you brush your teeth? ______________________________		
21.	How often do your floss your teeth? ______________________________		
22.	Did you ever wear braces?	☐	☐
	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?	☐	☐

____

____

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	☐	☐	Heart Problems	☐	☐
ADHD	☐	☐	Hepatitis: Type ________	☐	☐
Allergies	☐	☐	Herpes/STD	☐	☐
Anemia	☐	☐	HPV Vaccine	☐	☐
Anxiety	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	High Cholesterol	☐	☐
Artificial Heart Valves	☐	☐	HIV/AIDS	☐	☐
Artificial Joints	☐	☐	Immune Deficiency	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Back Problems	☐	☐	Low Blood Pressure	☐	☐
Bleeding Abnormally	☐	☐	Low Cholesterol	☐	☐
Bruise Easily	☐	☐	Mitral Valve Prolapse	☐	☐
Cancer: ______________	☐	☐	Neck Problems	☐	☐
Chemical Dependency	☐	☐	Osteoporosis	☐	☐
Chemotherapy	☐	☐	Osteopenia	☐	☐
Chest Pains	☐	☐	Pacemaker	☐	☐
Circulatory Problems	☐	☐	Radiation Treatments	☐	☐
COPD	☐	☐	Respiratory Disease	☐	☐
COVID-19	☐	☐	Shortness of Breath	☐	☐
Depression	☐	☐	Sleep Apnea	☐	☐
Diabetes: ___________	☐	☐	Smoker/Dipper	☐	☐
Emphysema	☐	☐	Stroke	☐	☐
Epilepsy	☐	☐	Swelling of Feet/Ankles	☐	☐
Glaucoma	☐	☐	Thyroid Problems: High or Low	☐	☐
Headaches / Migraines	☐	☐	Tuberculosis	☐	☐
Heart Murmur	☐	☐	Tumor/Growth on Head/Neck	☐	☐

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: __________

Patient Medication List

Patient Name: ______________________________ Date of Birth: ______________________

Medication	**Reason for Taking**

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 required for all appointments that involve 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. Our office is closed Friday. 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.

If you fail to give adequate notice, the deposit will remain on the account until you either reschedule the appointment, or it can be used for other dental care that does not require a deposit. **If you should fail to give a notice of 72 business hours before a rescheduled appointment, the money will be used for chair time.** If a third reschedule is necessary, a prepayment of 100% will be required.

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 day of service**. If you have dental insurance, we will accept assignment 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 to the above terms, please ask before scheduling treatment.

Patient: ____

Date: ____

Signature: ____

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: __________________

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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): __________________