Patient Information:

Full Name: _____ Pref. Name: _____

Street Address: _____Unit/ Apt #_____

City_____ State _____ Zip Code: _____

Home Phone:_____ Work: _____ Cell:_____

Birth Date: _____ Social Security #_____

Sex: Male Female Email Address: _____

Emergency Contact:_____ Phone: _____

Responsible Party: Fill out if the responsible party is someone other than the patient:

Full Name: _____

Address:_____

City: _____ State:_____ Zip Code:_____

Birth Date: _____ Phone:_____

Insurance Information:

Patient's Relationship to insured (circle): Self Spouse Dependent Other: _____

Name of Primary Subscriber or Policy Holder: _____

Primary's Birth Date: _____ Cell: _____

*Primary Subscriber's address is the same as: ☐ Patient's address ☐ Responsible party's address

If different Address: _____

City: _____ State:_____ Zip Code:_____

Subscriber's: ID or Subscriber's Social Security #_____

Name of Dental Insurance Company: _____

Employer:_____ Group# _____

Who should we thank for referring you?

☐ Newspaper ☐ Flyer ☐ TV Commercial ☐ Online Ad ☐ Your Insurance Company

Other: _____

Aloha Dental

Oral Cancer Enhanced Screening

Insurance does not pay for everything, even services that you and your dentist have good reason to think you need.

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health for our patients.

One American dies every hour from oral cancer. 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. Studies also suggest that human papilloma virus (HPV 16/18) plays a role in more than 20% of oral cancer cases.

We have incorporated the VELscope Vx into our oral screening standard of care. We find that using VELscope Vx along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope Vx is similar to proven early detection procedures for other cancers such as mammography, Pap smear and PSA. It is a simple and painless examination that gives the best chance to find any oral abnormalities at the 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 exam will be offered to you annually.

O **Yes, I authorize the enhanced examination which is recognized by the American Dental Association. This exam might not be covered by your insurance. The fee for this enhanced examination is $30.**

O **No, I would prefer not to have the VELscope Vx exam at this time. I hereby release from liability Aloha Dental dentists, hygienists, employees or agents from any injury I may currently, or in the future suffer as a result of my refusal to proceed**.

Patient/Guardian Signature_____ Date _____

Aloha Dental

Health Insurance Portability Act (HIPAA)

Acknowledgment Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this consent I authorize Aloha Dental to use and disclose my protected health information to carry out:

Treatment, including direct or indirect treatment by other healthcare providers involved in my treatment.

Obtaining payment from third party payers, e.g. patient's insurance company.

The day-to-day healthcare operations of Aloha Dental.

Securing Payment, including the release of any information necessary to obtain payment for services rendered.

I have also been informed of, and given the right to review and secure a copy of Notice of Privacy Practice, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Aloha Dental reserves the right to change the terms of this notice from time to time and that I may contact Aloha Dental at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations. However, I acknowledge that Aloha Dental is not required to agree to these request restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

By signing below, I acknowledge that I have read and understood this consent form and agree to its terms.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____

Aloha Dental's Financial Policies

Aloha Dental is committed to providing exceptional care while understanding the financial considerations that impact your choices. We are dedicated to offering flexible payment options to ensure quality dental treatment is accessible to all our patients.

Insurance and Payment Policies We work with most PPO insurance companies/organizations, and take great care in maximizing your benefits to better utilize your care. Our team meticulously documents procedures and coordinates with your insurer to facilitate the process. We also handle claim submissions and are available to address any questions you may have regarding your coverage.

Please note that you are responsible for any portion of your treatment not covered by insurance. Insurance companies will not guarantee payment, only let us know if there is an available benefit. To continue offering high-quality care, we request that your portion of the payment be made at the time of service. Any remaining balance after insurance payments will be billed. For qualified patients, we are happy to develop a payment plan that accommodates your needs. Additionally, we accept most major credit cards for your convenience.

Appointment and Cancellation Policy Your appointment time is reserved exclusively for you. To ensure personalized attention, we do not double-book our schedule or accept walk-ins, except in cases of emergency. As such, cancellations, especially on short notice, can disrupt our ability to serve all our patients effectively.

While we understand that unexpected circumstances may arise, repeated or last-minute cancellations can negatively impact your dental health and our practice operations. We kindly ask that you provide at least 48 hours' notice if you need to reschedule or cancel an appointment. Failure to do so will result in a $50 fee per scheduled hour.

We value your time and are dedicated to delivering the highest standard of professional and personal care. We appreciate your understanding and cooperation in helping us maintain a well-organized schedule for all our patients.

Sincerely,

Dr. Mark W. Jumper II

I acknowledge and agree to the above policies.

Patient/Guardian Signature_____ Date: _____

NON-COVERED INSURANCE EXAMS WAIVER

Insurance does not pay for everything, even services that you and your dentist have good reason to think you need. We do our best to keep up with your insurance company and get general copies of your coverage 48 hours prior to your appointment to make sure we have the most up to date information possible.

In this fast changing insurance world, even insurance companies are unable to keep up with their changes and refuse to guarantee anything until a claim is actually processed.

Insurance may or may not pay for some or all of the following services indicated below, despite our best

efforts:

- Panoramic, Periapical and Bitewing x-rays (used for wisdom teeth, emergency evaluations, periodontal disease, bone loss, infection and carries detection)
- Resin, or tooth colored fillings (insurance may down-grade to cost of amalgam or silver fillings)
- Waiting periods for treatment (periodontal disease, lost or broken crowns and veneers, root canal treatment, to name a few)
- Tooth colored crowns
- Intravenous Conscious Sedation, Nitrous gas sedation, or other medicaments
- Policy cancelled for any reason
- Frequency Limits
- Cancer Screenings
- Any other reason_____

By signing below, you authorize these services to be completed. You understand that you are responsible for any balance your insurance may not pay due to their reimbursement policies they may have with your employer.

We will help appeal any claim that is unpaid. In the end, if insurance does not pay, you promise you will.

Patient/Guardian Signature_____ Date _____

CONSENT TO USE ELECTRONIC COMMUNICATIONS

Aloha Dental would like permission to use electronic communications for automated reminders, confirmations, upcoming events and promotions. This is a great tool to utilize when a phone call is not convenient. Please indicate if you would like to receive email and text message appointments regarding confirmation and reminders, newsletters, and opportunities to provide feedback. Please check the box below to give your consent.

[ ] I consent and opt in to receive text messages from Aloha Dental. ***Standard messaging rates may apply.**

[ ] I consent and opt in to receive emails from Aloha Dental.

[ ] I DO NOT give consent for Electronic Communications

***You can opt out at any time by replying 'STOP' to any message. Please note that messaging is not a secure form of communication, and we recommend discussing any sensitive or personal information during your office visits. Please note that you are responsible for providing our office with any updates to your email address and/or cell phone number.

Social Media / Photo Consent Form

Aloha Dental would like permission to use images taken of your teeth on our social media platforms. They may include:

[ ] Aloha Dental Website

[ ] Facebook

[ ] Instagram

[ ] TikTok

[ ] Twitter

[ ] Advertisement

[ ] I DO NOT give consent for the use of imaging on social platforms

Patient/Guardian Signature:_____ Date: _____