Jeffrey B. LaMura, DDS, PLLC
135-104 Parkway Office Court Suite 104
(919)233-3545

Dear Patient:

Welcome to Dr. LaMura's dental office. We are pleased that you have chosen us for your dental needs and we will do everything we can to make your visit a pleasant and comfortable experience. Please do not hesitate to ask questions regarding treatment today.
Please note: we are limited on space in the patient waiting area. Therefore, we ask that you limit the number of people accompanying you to your appointment.

The following information is VERY important to keep in mind when scheduling an appointment with our dental office.

* If you make an appointment, you are expected to keep your appointment. However, we understand that emergencies arise. If you cannot keep your appointment, you MUST GIVE a 24 HOUR FOR ROUTINE CLEANING AND a 48 HOUR FOR RESTORATIVE NOTICE OF CANCELLATION. If you do not give proper cancellation notice or fail to show for a scheduled appointment you will be assessed a $50.00 cancellation fee, if on more than ONE occasion, we will be unable to provide you with another appointment and will request that you choose another dentist to serve your needs.
* Children under the age of 18 must have a parent or guardian in our office throughout the entire appointment.
* Please keep our office updated on changes in address, phone number, or insurance changes.

Thank you for your cooperation. We appreciate the opportunity to serve you.

_____ _____

Patient or Guardian Signature Date

Patient Registration

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Home Phone: (___) _____

City: _____ State/Zip: _____ Work Phone: (___) _____

Birth Date: _____ Age: _____ Cell Phone: (___) _____

Sex: oMale oFemale Marital Status: _____ Social Security Number: _____

Email address: _____

EMERGENCY CONTACT: _____ Phone Number: _____

How would you prefer to receive appointment reminders? Please choose one.
oPhone Call – If so, which number: _____ oEmail oText Message

How did you hear about our office? _____

Dental Insurance Information:

Person responsible for account: _____
Last name First name Initial

Relationship to patient:_____ Date of Birth:_____ Soc. Sec. #:_____

Responsible party's employer: _____ Business phone:_____

Insurance company: _____ Phone number: _____

Group number: _____ Patient ID: _____

Responsible Party (If someone other than patient)

Name: _____ Date of Birth: _____

Address: _____ SS#: _____

_____

Home #: _____ Work #: _____ Cell #: _____

Regarding HIPAA:

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you information about our privacy practices. By signing below, you are acknowledging you have reviewed a copy of our HIPAA privacy handout.

Signature: _____

Date: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Your Primary Physician's Name & Phone Number: _____

Conditions	Conditions	Conditions
Y N Heart Murmur	**Y N** Liver Disease	**Y N** Artificial Heart Valve
Y N Venereal Disease/STD's	**Y N** Kidney Problems	**Y N** Artificial Bones/Joints
Y N Ulcers	**Y N** HIV+/AIDS	**Y N** Arthritis
Y N Tuberculosis	**Y N** High Blood Pressure	**Y N** Angina Pectoris
Y N Thyroid Problems	**Y N** Hepatitis B	**Y N** Anemia
Y N Stroke	**Y N** Hepatitis A	**Y N** Allergies
Y N Sinus Problems	**Y N** Hepatitis C	**Y N** Sickle Cell Anemia
Y N Hemophilia	**Y N** Abnormal Bleeding	**Y N** Cancer-Chemotherapy
Y N Heart Attack/Date: _____	**Y N** Reflux	**Y N** Blood Transfusion
Y N Shingles	**Y N** Hay Fever	**Y N** Asthma
Y N Seizures	**Y N** Glaucoma	**Y N** Fainting Spells
Y N Rheumatic Fever	**Y N** Frequent Headaches	**Y N** Drug Abuse
Y N Radiation Therapy	**Y N** Cold Sores/Fever Blisters	**Y N** Low Blood Pressure
Y N Colitis	**Y N** Psychiatric Problems	**Y N** Diabetes
Y N Pace Maker	**Y N** Emphysema	**Y N** Congenital Heart Defect
Y N Mitral Valve Prolapse	**Y N** Difficulty Breathing	**Y N** Pre-Med

Do you smoke or use tobacco: Yes ○ No ○

Have you ever used the drug "Fen-Phen"? Yes ○ No ○

*Any other condition(s) not listed, please describe here:

_____

Allergies:

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Sulfa
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Tetracycline

Other: _____

Females Only:

Y N Are you taking birth control pills?
Y N Are you nursing?
Y N Are you pregnant?
# of weeks _____

Please list any medications you are currently taking: _____

_____

I request and authorize Dr. Jeffrey LaMura and/or his associate and assistants to examine, clean and provide my/the patient's dental treatment as necessary. I further request and authorize the taking of dental x-rays/photographs as may be considered necessary for diagnostic or educational purposes. **I understand that this office only uses composite (tooth-colored) filling material to restore teeth and amalgam (silver) is not available. I will be responsible for any charges incurred on this account.**

Signature: _____ Date: _____

In our continuing efforts to enhance patient care, this practice is proud to announce the inclusion of the ViziLite® Plus exam as an important part of our annual comprehensive oral screening program.

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**.

According to the American Cancer Society, more women in the United States will be diagnosed with oral cancer this year than will be diagnosed with cervical cancer, and now **studies show an increasing link between the human papilloma virus (HPV 16/18) and oral cancer.**

The ViziLite Plus exam is used after the standard visual oral cancer examination and can help to identify suspicious areas that may have been missed during the conventional examination. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless examination that gives this practice a better chance to find any oral abnormalities you may have at their earliest possible stage.

Oral cancer risk by patient profile is listed below:

Oral Cancer Risk profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with 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% oral cancers occur in people who **don't** smoke **and** have no other risk factors.

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. We will be performing the ViziLite Plus exam annually following the standard oral cancer examination of the oral cavity for a fee of **$67.00**

Please initial stating you have read and reviewed information. This does not mean you are required to have it complete, but that we did inform you of treatment option.

Initial_____ Date_____

Jeffrey B. LaMura DDS, PLLC
135 Parkway Office Court Suite 104
Cary, NC 27518
919-233-3545

Our Financial Policy

Thank you for choosing us for your dental care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we request you **read and sign.**

Regarding insurance……..

Our practice participates with the following insurance plans: **Delta Dental, Dentemax, MetLife, Careington, Aetna, United Concordia, United Healthcare, Connection, Guardian, Humana, GEHA, and Blue Cross Blue Shield.** If you have any questions whether or not our practice participates with you particular plan, please speak directly with the receptionist. If your plan is one with which we participate, we will file insurance and collect according to your plan. All deductibles, co-payments, and disallowed charges will be due at the time of service.

We will do all that we can to get the most in benefits reimbursed for you. However, we cannot bill your carrier for your reimbursement unless you provide us with current and correct insurance information. Please be aware that some of the services provided may not be covered or considered above the "usual and customary." Our practice is committed to providing the best treatment for our patients, while charging what is reasonable and customary for our area. **You are responsible for payment of your account, regardless of any insurance company's arbitrary determination of usual and customary fees. We can only estimate patient portion based upon usual and customary fees. It is not a guarantee of actual insurance payment. If insurance has not responded to a claim within 60 days of submittal, the full account balance becomes the account holder's responsibility.**
Please note to benefit our patients we will file any secondary insurance, however we will not wait for payment from secondary insurance. Your secondary provider will reimburse you directly.

Thank you for reading and understanding our financial policy. Please let us know if you have any questions of concerns.

_____ _____

Patient or Guardian Signature Date

In order to accept assignment of benefits, we now require that a credit/debit card be left on file with our office.

☐ Balance of charges not paid by Insurance within 60 days and not to exceed $50.00. We will call on all balances over $50.00 for authorization before charging your credit card.

☐ Any overpayment on the account will be refunded to the same credit card I use for payment.

I assign my insurance benefits to the provider listed above. I understand this form is valid unless I cancel the authorization through written notice to **Dr. Pressley** and provide alternative payment for committed amount. I understand that this credit card information will not be shared with any outside sources.

Patient Name: _____

Cardholder Name: _____ Home Phone: _____

Cardholder Address: _____ Cell Phone: _____

City, State, Zip: _____

Account Number: _____

Expiration Date: _____

3 Digit Security Code (on signature block): _____

Please choose one: Visa / Mastercard / Discover

Cardholder Signature: _____ Date: _____

Witness: _____ Date: _____