

DANIEL E. CASSIDY, JR., D.D.S.
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IMPORTANT MEDICAL ALERT

A connection between **Fosamax** and other bisphosphonates with a serious bone disease called Osteonecrosis of the Jaw (ONJ) has been found.

Biphosphonates are commonly used in tablet form to **prevent and treat osteoporosis** in post-menopausal women. They are also used in **treatment of Paget's disease**. Stronger forms given orally or intravenously (IV) are commonly used in the **management of advanced cancers** including, but not limited to, lung cancer, breast cancer, prostate cancer & multiple myeloma.

Have you taken any of the following bisphosphonates?

| | |
|---------------------------------|---------------------------|
| Y N Aledronate (Fosamax) | Y N Raloxifene (Evista) |
| Y N Clodronate (Bonefos, Ostac) | Y N Risedronate (Actonel) |
| Y N Etidronate (Didronel) | Y N Teriparatide (Forteo) |
| Y N Ibandronate (Boniva) | Y N Tiludronate (Skelid) |
| Y N Pamidronate (Aredia) | Y N Zoledronate (Zometa) |

If yes, when? _____

Prescribing Doctor: _____
(Name) (Phone)

1. Financial Responsibility

I certify that the information I have provided regarding my insurance coverage is correct and authorize Dr. Daniel E. Cassidy's office to verify insurance coverage and benefits allowed in accordance with my insurance plan's policies.

I agree to pay any copayments, or deductibles as required by my insurance plan for dental care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan.

Dr. Daniel E. Cassidy's office may impose reasonable interest, late charges, direct collection agency costs and or reasonable attorney's fee should my account become delinquent.

Dr. Daniel E. Cassidy's office may impose a no-show fee of \$65.00 for appointments not cancelled 24 hours in advance.

2. Release of Medical Information For Billing

I hereby authorize Dr. Daniel E. Cassidy's office to submit a claim to my insurance company.

I also authorize Dr. Daniel E. Cassidy's office to provide a copy of this release and a copy of dental records related to such services if requested by the payor. Further, I authorize Dr. Daniel E. Cassidy's office to release dental health information to my primary care physician, and or other dental specialists to assist with continuity of my dental health care.

3. Non-Covered Services

I agree to pay for dental services provided to me or my dependent which are not covered by the benefits in my insurance plan.

I Agree to the Above Stated Responsibility and Consent

Signature of Patient or Legal Guardian

Date