Davis Dental

PATIENT INFORMATION FORM

NAME:_____BIRTHDATE:_____

SS#_____ MALE [ ] FEMALE [ ] OTHER [ ] MARITAL STATUS_____

ADDRESS:_____CITY:_____STATE:_____

ZIP CODE:_____ EMAIL:_____

PHONE #: ( ) _____ WORK PHONE#: ( ) _____

EMERGENCY CONTACT NAME:_____PHONE #:_____

HOW DID YOU HEAR ABOUT OUR OFFICE: _____

INSURANCE INFORMATION *** (PROVIDE COPIES OF CARDS)**

PRIMARY INSURANCE_____

EMPLOYER _____GROUP #_____ID #_____

POLICY HOLDER _____BIRTHDATE_____SS#_____

RELATIONSHIP TO PATIENT: [ ] SELF [ ] SPOUSE [ ] PARENT [ ] OTHER

SECONDARY INSURANCE_____

EMPLOYER _____GROUP #_____ID #_____

POLICY HOLDER _____BIRTHDATE_____SS#_____

CANCELLATIONS If you find that you must change your appointment, we require a minimum of 48 hours' notice so that we may make every effort to accommodate other patients. If proper notice is not received, a fee $35.00 will be charged for every appointment cancelled within 48 business hours Monday thru Thursday.

LATE ARRIVAL POLICY As a courtesy to our other patients, if you arrive to your appointment more than 15 minutes late, you may have to be rescheduled.

Patient signature:_____ Date:_____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Do you need to pre-medicate? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Do you have history of joint replacement? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Current list of medications: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Davis Dental

Financial Agreement

Thank you for choosing Davis Dental for your dental needs. We are committed to providing you with excellent care. Our financial agreements are based on an open and honest discussion of recommended treatment options, respective fees and patient's financial capabilities.

Insurance

Insurance policies vary greatly, we can only **estimate** your coverage in good faith, but **cannot guarantee it.** As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with treatment that best meets your needs, not to treatment plan only what is covered by your insurance. Ultimately, the contract is between you and the insurance company; therefore, all charges are your responsibility. We are not party to that contract. It is physically impossible for us to have knowledge and keep track of how you use your benefits and if you have used them at other offices. Please understand that we have no leverage to obtain payment from your insurance carrier. We encourage you to become familiar with your policy exclusions, deductibles, & required co-insurances payments.

Our expectations of the policy owner:

- Payment of fees not covered by your insurance company are to be paid at the time the services are rendered. Initial_____
- To recognize that dental insurance policies restrict payment for services and exclude some procedures based on prior conditions or length of time on the plan, or many other reasons listed in your benefit booklet Initial _____
- Prior Authorization is not a guarantee of payment and you will be financially responsible for balance. Initial_____
- To take responsibility for payment if the insurance company does not pay our office within 90 days Initial_____
- To keep our office informed of any changes in your insurance coverage or employment Initial _____
- To be aware that some and possibly all of the services provided may not be covered by your insurance provider. Services which are not covered, downgraded or considered not medically necessary by your insurance company are your responsibility. Initial _____
- All charges not paid by your insurance are your responsibility regardless of the reason for non-payment Initial _____
- Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate Initial _____

Down Payment

You may be asked to leave a deposit for long appointments. If the appointment is cancelled with less than 48 hours, the deposit will be non-refundable. Otherwise, your deposit will be applied to the cost of your procedure.

Missed Appointments

Once an appointment has been made, that time is reserved specifically for you. Patients who do not show up or cancel with less than **48 business hours** (Monday thru Thursday) are subject to a $35 late cancel fee. You may be asked to make a non-refundable deposit before being reappointed.

*I hereby authorize Davis Dental to release to my insurance company any information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Davis Dental. I understand that **ESTIMATES** given to me by Davis Dental regarding my insurance are **not a guarantee of payment.** I am responsible for any unpaid balance after my insurance pays.*

Printed Name	Signature	Pt #	Date
_____	_____	_____	_____

HIPAA Compliance Patient Consent Form Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Weisfogel Sleep Disorder Assessment

Your physician requests that you complete this Sleep Disorder Assessment Form. This form evaluates the need for you to have a sleep test. The sleep test will determine if you have a sleep disorder. Sleep disorders negatively affect your well-being, especially your cardiovascular health. Sleep disorders can be treated effectively.

Date: _____ Name: _____ Date of Birth_____

Phone Number _____ Physician Name: _____

1. Have you ever been given a CPAP device?..... Yes ___ No___
2. If you have been given any form of CPAP, do you use it nightly?..... Yes ___ No___
3. Are you comfortable with your CPAP and satisfied with its use?..... Yes___ No___

If the answer is "Yes" to all three questions, YOU ARE DONE!

If your answer is **"No"** to any of the above questions, please continue to ***Part 1***.

Part 1 ***Epworth Sleepiness Scale***

How likely are you to doze off while doing the following activities? Please use the following scale:
0 = never, 1 = slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more. 0 1 2 3
2. Sitting and talking to someone..... 0 1 2 3
3. Sitting and reading..... 0 1 2 3
4. Watching TV..... 0 1 2 3
5. Sitting inactive in a public place..... 0 1 2 3
6. Lying down to rest in the afternoon..... 0 1 2 3
7. Sitting quietly after lunch without alcohol..... 0 1 2 3
8. In a car, while stopped for a few minutes in traffic..... 0 1 2 3

Total ESS: ____

Part 2

1. Have you been told that you snore?..... Yes___ No___
2. Does your family have a history of premature death in sleep?..... Yes___ No___
3. Do you have diabetes?..... Yes___ No___
4. Have you ever been told you have coronary artery disease?..... Yes___ No___
5. Do you have high blood pressure?..... Yes___ No___
6. Have you ever experienced irregular heart rhythms?..... Yes___ No___

Part 3

1. Have you ever been diagnosed with sleep apnea? ..... Yes___ No___
2. Do you awaken from sleep with chest pain or shortness of breath? Yes___ No___
3. Has anyone said that you seem to stop breathing while sleeping? .. Yes___ No___
4. Is your neck size larger than 15" (female) or 16.5" (male)..... Yes___ No___
5. Have you ever had a stroke?..... Yes___ No___
6. Have you ever been told you have congestive heart failure?..... Yes___ No___
7. Do you have or did you ever have atrial fibrillation?..... Yes___ No___

Actual Neck Size:

Davis Dental

Informed Consent for Exam and Cleaning

I hereby give consent to Dr. Davis and staff to perform x-rays, exam and cleaning and any such additional procedure(s) as may be considered necessary for my well-being based on findings made during the course of recommended treatment. The nature and purpose of the recommended treatment have been explained to me and no guarantee has been made to me or implied as to result or cure. I have been given satisfactory answers to all of my questions, and I wish to proceed with recommended treatment. I also consent to the administration of local anesthesia during the performance of recommended treatment. Treatment options have been discussed with me.

I understand that there are risks and complications associated with the administration of medications, including anesthesia, and performance of the recommended treatment. The potential risks and complications, include but are not limited to, the following:

1. Drug reactions and side effects
2. Post-treatment bleeding, oozing and infection
3. Bruising and/or swelling, delayed healing, restricted mouth opening for several days or weeks
4. Varying lengths and degrees of sensitivity
5. Increased spacing between teeth due to removal of hard deposits
6. Revealing of recessed gums
7. Increased mobility
8. As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues which is typically temporary but in rare instances, may be permanent.

I understand that my visit will require radiographs in order to complete the examination, diagnosis and treatment plan.
Risks:

- With any radiation the risk associated with dental radiography is primarily that of cell mutation
  -However, risks from dental radiography fall into the lowest risk category
- In case of pregnant women, x rays will be taken only when benefits outweigh the risks unless we have written consent from your OB/GYN

- Please inform us if you think you are pregnant

Benefits:

- Detection of decay
- Detection of pathology of the bone or tooth
- Bone loss associated with periodontal
- Integrity of existing fillings
- Impacted or unerupted teeth

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialist, and return for the recommended cleaning rotation (3, 4 or 6 months). If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome and possibly require additional or more extensive treatment.

If you are a woman on birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

CONSENT:

I understand that dentistry is not an exact science, therefore: reputable practitioner cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I understand the potential benefits, risks and complications of recommended treatment. This form is intended to provide you with an overview of potential risks and complications. Please be certain that all of your concerns have been addressed to your satisfaction before commencing treatment.

Printed Patient Name:_____

Signature:_____ **Date:** _____
(patient, legal guardian or authorized agent of the patient)

Patient ID: _____

Today's procedure:_____