PATIENT INFORMATION

First Name: ______________ Last Name: ______________ Middle Initial: ______

Preferred Name: ______________ Occupation: ______________

Address: ______________ City: ______________ Zip: ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed

Date of Birth (mm/dd/yyyy): ______________ Social Security #: _____-_____-_____ Drivers Lic: ______________

Email Address: ______________

Would you like to receive confirmations via: O Email O Text

What days & times are you available on short notice for appointments? ______________

PARENT/GUARDIAN INFORMATION: (For minors)

Father's Name: ______________ Cell Phone: ______________

Mother's Name: ______________ Cell Phone: ______________

EMERGENCY CONTACT: (Person to notify in case of emergency)

Name: ______________ Cell Phone: ______________

Relationship to patient: ______________

Please check all of the ways that you have heard about us

O Radio
O Phone Book
O Drive by / Sign
O Postcard / Mailer
O Website
O Referred by Patient/ Friend: ______________
O Online Search Engine (ie. Google): ______________
O Other: ______________

THE WAY WE SCHEDULE

You will love how we make appointments at Dutchtown Dental Center. We have actually written an agreement for you to read and sign to explain how we schedule our appointments. This ***agreement will assure that you will rarely wait for your appointments here at our office***. You know how when you go to a doctor's office you sign a clip board when you arrive? That's because they have scheduled multiple people at your appointed time. We ***do not double or triple book our rooms***, so when you are scheduled, that **time is reserved for you and only you**. Therefore, it is **important that you are on time for your appointment**. The day we make your appointment we consider it confirmed, but as a courtesy to you, we will contact you the day before your appointment as a reminder. As a result of this process, your appointment cannot be changed without 24-48 hour notice. We understand that circumstances arise that cause us to change our schedules, as long as we have this notice, we will be able to reschedule your appointment the day we speak to you. If you are unable to give us 24-48 hours notice you will be put on a "Short Term" list and we will call you to reschedule your appointment when our schedule allows time. This allows us to be able to see emergency patients on the same day and will also allow you to run your personal schedule more efficiently as you will know when your appointment begins and when it ends and RARELY HAVE TO WAIT!!! Our patients love this system, and we're confident that you will also. Thank you for your cooperation and understanding and may God bless you & yours!!

- **With respect to discounts – only ONE can apply at a time. No combining discounts at time of service.**
- **All prepaid dental treatment is non-refundable after 30 days of payment, due to fees being used on supplies, materials and labs associated with treatment.**

Patient's name (please print): ______________

Patient's signature: ______________ Date: ______________
(Parent/Guardian's signature if patient is a minor)

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 medications 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? O Yes O No If yes, explain: ______________________________
- Have you ever been hospitalized or had a major operation? O Yes O No If yes, explain: ______________________________
- Have you ever had a serious head or neck injury? O Yes O No If yes, explain: ______________________________
- Are you taking any medication, pills, or drugs? O Yes O No If yes, explain: ______________________________
- Do you take, or have you taken, Phen-Fen or Redux? O Yes O No
- Have you ever taken Fosamax, Boniva, Acetonel or any other medications containing bisphosphonates? O Yes O No
- Are you on a special diet? O Yes O No
- Do you use tobacco? O Yes O No
- Do you use controlled substances? O Yes O No

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

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex O Sulfa Drugs
O Other If yes, please explain: ____

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

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

- **Have you ever had any serious illness not listed above?** O Yes O No ______________________________
- **Are you nervous about dental visits?** O Yes O No
- **Do you need antibiotic pre-medication before dental visits?(for reasons such as Mitral Valve Prolapse or artifical joints?)** O Yes O No
- **Do you snore, wake up with headaches, or have trouble remembering things?** O Yes O No

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: ______________________________

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA'), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices which contains a complete description of the use and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time to obtain a current copy of the *Notice of Private Practices.*

Patient's name (please print): ____

Patient's signature: ______________________________ Date: ______________
(Parent/Guardian's signature if patient is a minor)

Relationship to patient (if patient is minor): ______________________________

Anyone you want allowed access to your file: ______________________________

INSURANCE FILING INFORMATION

As a courtesy to you and your family, our office will work with your insurance company on your behalf in order to help you get the most out of your coverage. According to Louisiana State law, dental insurance companies are required to respond to a claim within **30 days** of receiving the claim. If we have not received an insurance payment by the 30 day point, we will call them for you and let you know the status of your claim and if need be, encourage you to get involved if there is an issue. ***At 45 days, however, your fee will be due and payable to our office in full, regardless of the outcome of the claim. Our agreement to treat you is a contract between you and our office. We are not responsible for any undesirable response from your insurance company as we don't have a relationship with them, you do. We require keeping a credit card on file in the event your account is past 45 days. We will always call you when any payments are made on your card.***

Credit Card Type: VISA MC DIS AMEX Credit Card #: ______________________________

Exp. Date: ______________ Billing Zip: ____________

Patient Signature: ______________________________ Date: ______________

I hereby authorize payment directly to Dutchtown Dental Center of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of any treatment provided.

______________________________ ______________
Signature **Date**

CONSENT FOR DENTAL TREATMENT AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for dental treatment. Please ask us about anything you do not understand. We are ready to answer any of your questions or explain anything you do not understand.

There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or pre-medication prior to dental care being rendered. Some of these risks/complications are, but are not limited to, the following:

Infection	Injuries to adjacent teeth and/or hard, soft tissue
Bleeding	Dry Socket
Failure of wound to heal	Incomplete removal of tooth
Loss of teeth	Injury to adjacent structures
Loss of bone	Allergic reaction to drugs
Instrument breakage	Tooth or fragment in maxillary sinus
Bacterial endocarditis	Death (in rare cases)
Breakage of root(s) and retained root fragments	Parasthesia or numbness of tongue and/or mouth, and/or face
Swallowing and/or aspiration of objects	Fracture of mandible (lower jaw) or maxilla (upper jaw)
Failure of treatment to accomplish main purpose	Slough (unanticipated loss of hard and/or soft tissue)
Trismus (jaw pain or difficulty opening mouth)	Opening between mouth and sinus or mouth and nose

Additional oral surgery, hospitalization, and/or further treatment may be required in the event of any complication(s).

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions were answered to my satisfaction.

I hereby authorize and direct the dentist and/or associates, hygienist, and assistants of their choice to perform the diagnostic, surgical, orthodontic or dental treatment agreed upon between doctor and patient or parent/guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated. This consent form will remain valid unless revoked by me in writing.

I understand that payment for all treatment and services rendered is my responsibility regardless of any presumed insurance benefit.

______________________________ ________________
Patient's Signature Date

______________________________ ________________
Parent/Guardian's Signature (if patient is a minor) Date

OUR PROMISE

Our goal is to give our patients the best quality dentistry possible at affordable fees. We stand behind the work that we perform on our patients. However, please be aware that, just as in medicine, there are no guarantees when dealing with the human body/mouth and dentistry. In order to best serve our patients, we stand behind our services in the way that is outlined below:

1. Any repairs/replacements will be redone at no charge within 6 months of initial date of service.
2. After 6 months and 1 day through 12 months from initial date of service, 25% of the initial cost will have to be paid to replace or redo any dental work done.
3. After 12 months and 1 day through 18 months from initial date of service, 50% of the initial cost will have to be paid to replace or redo any dental work done.
4. After 18 months and 1 day through 24 months from initial date of service, 75% of the initial cost will have to be paid to replace or redo any dental work done.
5. After 24 months (2 years), the patient is responsible for the full fee of any service required to replace or redo any dental work done.

This policy is only valid when the patient maintains regular 6 month checkups and accepts the treatment recommended at the time of the initial exam.

The above policy has been explained to me and I fully understand the conditions of this policy.

______________________________ ________________
Patient Signature (Parent / Guardian if minor) Date

OSA SCREENING FORM

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
(0=never, 1=slight, 2=moderate, 3=high chance of dozing) – CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading…………………………………………………………	0	1	2	3
Watching television……………………………………………………….	0	1	2	3
Sitting in a public place………………………………………..………..	0	1	2	3
As a passenger in a car for one hour………………………….………..	0	1	2	3
Driving a car stopped for a few minutes in traffic………..……..	0	1	2	3
Sitting & talking to someone…………………………………………..…	0	1	2	3
Sitting down quietly after lunch without alcohol……………..……	0	1	2	3
Lying down to rest in the afternoon………………………………….	0	1	2	3

Total Score: ______

Section 2: Patient Evaluation

Fill in the blanks, circle one yes or no response for each question

		No(0)	Yes(1)
BMI (See Attached Chart):	______ Is it greater than or equal to 30?	0	1
Neck Circumference	______ Is it >17" (Men) or >15" (Women)?	0	1
Have you gained at least 15lbs in the past 6 months?		0	1

Total Score: ______

Section 3: Subjective Sleep Evaluation

Please circle one yes or no response for each question	No(0)	Yes(1)
Do you snore?..	0	1
You, or your spouse, would consider your snoring louder than a person talking….	0	1
Your snoring occurs almost every night…………………………………….……..	0	1
Your snoring is bothersome to your bed partner…………………………………......	0	1
Do you feel that in some way your sleep is not refreshing or restful?.......................	0	1
Do you wake up at night or in the mornings with headaches?................................	0	1
Do you experience fatigue during the day and have difficulty staying awake?...	0	1
Do you have trouble remembering things or paying attention during the day?....	0	1
Do you have high blood pressure?..	0	1

Total Score: ______

Section 4: Prior Diagnosis

	No(0)	Yes(1)
Have you previously been diagnosed with sleep apnea?	0	1

If Yes:

When were you diagnosed? (Approx mo/yr) ____________

Were you put on CPAP Therapy for treatment? ____________

Are you still using your CPAP every night? ____________

Total Score: ______

Notes: (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate use back of page if necessary.)

Patient Signature:_____________________________________ **Date:** ______________________________

OFFICE USE ONLY

Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.

______ ESS Score ≥ 8? _____ Pt. Eval ≥ 2? _____ Subjective Sleep Eval ≥ 3? _____ Prior OSA Diagnosis ≥ 1?