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? _____

Father's Name: _____ Cell Phone: _____

Mother's Name: _____ Cell Phone: _____

EMERGENCY CONTACT: (Person not living with you 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: _____

SCHEDULING AGREEMENT

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 and 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**. When we make your appointment, we assume that the appointment is a confirmed appointment, 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 once it is made. However, we understand that circumstances arise that cause us to change our schedules. SO, if you have to change your appointment, we will need 24-48 hrs notice to do so. As long as we have this notice, no fees will be charged to you for the schedule change. 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/Guardian's 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 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? 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 send claims, letters, x-rays and any other necessary information to your insurance company for reimbursement of your dental treatment. The deductible and estimated percentage your insurance company does not cover is to be paid in full upon the date of service. According to the Louisiana State law, insurance companies must respond within **30 days** of receiving a claim. ***After 45 days, any remaining balance from unpaid insurance claims (for example: rejected, denied or partial payments) will be your personal obligation.*** **We require to keep a credit card on file in the event your account is past 45 days. We will always call you prior to any payments made on your card.** *If you have a secondary insurance please notify a staff member prior to being seen. Thank you.

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 and dental treatment.

_____ _____
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, 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 Date

Our Promise to You

Our goal is to give our patients the best quality dentistry possible at affordable fees. We stand behind the work 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 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 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 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 work done.

This policy is only valid when the patient maintains regular checkups at a 6-month (or other recommended) interval 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

OBSTRUCTIVE SLEEP APNEA SURVEY

Patient Name (Print) _____

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 and 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 to each question.

		No (0)	Yes (1)
BMI:	_____ 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 15 lbs 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 morning 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 month/year) _____		
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 the back of the page if necessary.

Patient Signature: _____ **Date:** _____

Office Use Only

Advanced screening criteria: if any of the following are yes, the patient should be scheduled for advanced OSA screening.

_____ ESS Score ≥ 8 _____ Pt Eval ≥ 2 _____SSE ≥ 3 _____Prior OSA ≥ 1

Patient Name ----------
Date ----------

Sleep Apnea Screening

How likely are you to doze off in these situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	----------
Watching TV	----------
Sitting Inactive in a public place (ie. theater or a meeting)	----------
As a passenger in a car for an hour without a break	----------
Lying down to rest in the afternoon when circumstances permit	----------
Sitting and talking to someone	----------
Sitting quietly after lunch without alcohol	----------
In a car, while stopped for a few minutes in traffic	----------

DO YOU HAVE THESE SYMPTOMS?	Yes	No
Have you been told, or are you aware, that you snore loudly?	O	O
Do you sometimes wakeup choking or gasping?	O	O
Has someone witnesses you stop breathing, or pauses during sleep?	O	O
Do you wake up suddenly for no reason from your sleep?	O	O
Do you have periods of the day having trouble paying attention, or staying awake?		
Do you feel that in someway your sleep is not refreshing or restful?	O	O
Do you often feel tired, exhausted or sleepy during the day time?	O	O