Drs. McIntyre, Whiting, & Rockey—Smiles for Life

Patient Information

Today's Date _____ Patient Name (last, first, middle initial) _____

Preferred Name _____ Gender _____ Marital Status _____

Birthdate _____ SSN _____ Employer/School _____

Prefer contact by: ☐email ☐phone call ☐text

How did you hear about us? _____

Home Phone (____) _____ Street Address _____

City _____ State _____ Zip _____ Cell Phone (____) _____

Work Phone (____) _____ Email Address _____

Emergency Contact Information

IN CASE OF EMERGENCY, CONTACT (If possible, specify someone who does not live in your household.)

Name _____ Relationship _____

Phone (_____) _____ Alt. Phone (_____) _____

Dental Insurance Information

Do you have dental insurance? ☐ Yes ☐ No

If this is your own policy:

Is this through an employer? ☐ Yes ☐ No

Employer:_____

Insurance Co._____

ID #_____

Policy #_____

Group #_____

If you are on someone else's policy (parent, spouse, etc.):

Subscriber's Name_____

Relationship to Patient_____

Subscriber's Birthdate _____

Subscriber's SSN_____

Is this through an employer? ☐ Yes ☐ No

Insurance Co._____

Employer:_____

Policy #_____

Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company[ies]) and assign directly to Smiles for Life all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

The above-mentioned dentist may use my health care information and may disclose such information to the above-mentioned Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

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Epworth Sleep Questionnaire

Name _____

Date _____ Birthdate _____ Sex ☐ M ☐ F

How likely are you to doze off or fall asleep in the following situations?

No chance of dozing	**Slight** chance of dozing	**Moderate** chance of dozing	**High** chance of dozing	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in public place (e.g. a theater or 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 know of anyone in your family that snores, stops breathing while sleeping, is constantly tired, depressed, or (for children) hyperactive?

☐ **YES** ☐ **NO**

Do you sleep in a different room from your significant other due to sleep issues?

☐ **YES** ☐ **NO**

Here at *Smiles For Life,* we are not only concerned with your dental health but with your overall health and well-being. If you or anyone you know suffers from the above-mentioned issues, we are able to correct many of them with an oral sleep appliance.

Please let any of our team members know if you have any questions or concerns and we would be more than happy to help in any way possible.

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Acknowledgement of Receipt of Notice of Privacy Practices

TO THE PATIENT--PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice is posted at the front desk and a copy can be made available to you by request. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a new copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Becky McIntyre (Office Manager) **Telephone:** 540-828-2312 **Fax:** 540-828-2857
Email: smiles@smilesforlifeonline.com **Address:** 115 Oakwood Drive, Bridgewater VA 22812

This acknowledgement page will be retained in the patient's record.

I request that the following have access to my Personal Health Information:

Name _____ Full Access or Partial Access (Circle One)

If partial, I grant this person access to my: ☐ Health Information ☐ Treatment Information ☐ Financial Information

Name _____ Full Access or Partial Access (Circle One)

If partial, I grant this person access to my: ☐ Health Information ☐ Treatment Information ☐ Financial Information

Name _____ Full Access or Partial Access (Circle One)

If partial, I grant this person access to my: ☐ Health Information ☐ Treatment Information ☐ Financial Information

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment, activities, and health care operations.

Patient's Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name _____ Relationship to Patient _____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____