{NAME OF PRACTICE}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: 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 accompanies this Consent. 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 copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

Right to Revoke: You will 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.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your 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.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

MEDICAL HISTORY

Patient Name	H ealth Alert	B P:

1. Have you been under the care of a medical doctor during the past 2 years? . . . Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____

2. Have you taken any medication/drugs during the past 2 years? . . . . . Yes No

3. Are you taking any medication, drugs, or pills now? . . . . . Yes No
   If yes, please list name and dosage: _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance?
   If yes, please list:_____ . Yes No

5. Have you been a patient in the hospital during the past 5 years? . . . . . Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Tuberculosis……....Yes No	Cortisone Medicine……Yes No	Hepatitis A (infectious) B(serum)Yes No
Asthma……..Yes No	Swollen Ankles……Yes No	Venereal Disease……Yes No
Hay Fever……..Yes No	Stroke……Yes No	ALD.S……....Yes No
Latex Sensitivity ……..Yes No	Diet (Special Restricted)…….Yes No	HIV Positive……..….Yes No
Allergies/Hives ……Yes No	Artificial Joints (hip, knee)……..Yes No	Cold Sores/Fever Blisters …….Yes No
Sinus Trouble ……...Yes No	Kidney Trouble……Yes No	Blood Transfusion……Yes No
Heart(Surgery/Disease/Attack)..Yes No	Thyroid Problems……..Yes No	Hemophilia……....Yes No
Chest Pain……Yes No	Ulcers……Yes No	Sickle Cell Disease……..Yes No
Congenital Heart Disease……..Yes No	Diabetes……Yes No	Bruise Easily……Yes No
Heart Murmur……...Yes No	Glaucoma……..Yes No	Liver Disease……...Yes No
High Blood Pressure……..….Yes No	Contact Lenses……Yes No	Yellow Jaundice……....Yes No
Mitral Valve Prolapse……..…Yes No	Emphysema……..Yes No	Neurological Disorders……...Yes No
Artificial Heart Valve……....Yes No	Chronic Cough……Yes No	Epilepsy or Seizures ……..Yes No
Heart Pacemaker……Yes No	Radiation Therapy……....Yes No	Fainting or Dizzy Spells……..Yes No
Rheumatic Fever……Yes No	Chemotherapy……..Yes No	Nervous/Anxious……..Yes No
Arthritis/Rheumatism …….Yes No	Tumors……..Yes No	Psychiatric (Psychological Care)Yes No

7. Do you use more than two pillows to sleep? . . . . . Yes No

8. Have you lost or gained more than 10 pounds in the last year? . . . . Yes No

9. Do you have or have you had any disease condition, or problem not listed above? Yes No
   If yes, please list: _____

10. **Women** Are you: Pregnant? Yes, _____Months No **Nursing** Yes No
    Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe & efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have may permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1**/2%** finance charge will be added to any balance over 30 days In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs & reasonable attorney fees as may be required to effect collection of this note

Patient/Guardian Signature _____ Date _____

History Review

Doctor Signature Date

Patient Information

Patient Name:_____ Date:_____
Last, First MI (Preferred Name)

Gender: _____ Family Status: ☐ Married ☐ Single ☐ Child

Social Security #:_____ Birth Date:_____

Phone (Home):_____ (Work):_____ Ext:_____ E-Mail: _____

Address: _____
Street Apartment #

_____

Person to contact for emergency: _____ Telephone _____

Is another member of your family or relative a patient at our office? _____

Who may we thank for referring you to our office? _____

Responsible Party Information (if different than above)

Relationship to Patient: ☐ the patient's spouse ☐ parent or guardian ☐ other, _____

Name:_____

☐ Male ☐ Female

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Telephone: _____

Insurance Information

Please allow us to copy your Insurance Card

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Unlike medical offices where you come in and "wait your turn", we schedule appointment times specific to your treatment needs. These times are reserved just for you. If you do not give us adequate notice that you are unable to come – your appointment time is left open and someone who would have liked to come in, would not have been able to do so. Unless a scheduled appointment is cancelled 24 hours in advance, you will be billed $59.00 for the missed appointment of one hour or less, and $118.00 for a missed appointment of more than one hour.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. A minimum billing charge of $4.90 applies. I understand that fee estimates listed for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Patient Name _____

Medical Alert _____

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of the medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Date of last Dental Visit _____ last Dental Cleaning _____ last Full Mouth x-rays _____

What was done at your last dental visit? _____

Did any previous dentist recommend dental treatment that was never performed? Yes No

If yes, what type of work was it? _____

Why was this treatment never performed? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Rotodent, Interplak, toothpick, etc.) _____

Are any of your teeth sensitive to:

Hot or cold? ……. Yes No
Sweets? ……. Yes No
Biting or Chewing? ……... Yes No
Noticed any mouth odors or bad tastes? …. Yes No
Do you frequently get cold sores, blisters or any other oral lesion? ……... Yes No

Do your gums bleed or hurt? ……. Yes No
Have your parents experienced gum disease or tooth loss? ……. Yes No
Have you noticed any loose teeth or change in your bite? ……. Yes No
Does food tend to become caught between any teeth? …….. Yes No
If yes, where? _____

Do you:

Clench/grind teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? ……. Yes No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails) .. Yes No
Mouth breathe while awake or asleep? ….. Yes No
Have tired jaws, especially in the morning? Yes No
Smoke/chew tobacco? ……. Yes No

Do you feel nervous about dental treatment? Yes No
Ever had an upsetting dental experience? ... Yes No
If so, please describe _____

_____

_____

Have you ever had:

Orthodontic Treatment? ……. Yes No
Oral Surgery? ……. Yes No
Periodontal Treatment? ……... Yes No
Your teeth ground or bite adjusted? ……... Yes No
A bite plate or mouth guard? ……... Yes No
A serious injury to the mouth or head? …….. Yes No
If so, please describe, including cause _____

_____

Have you experienced:

Clicki ng or popping of the jaw? ……. Yes No
Pain? (joint, ear, side of face) ……. Yes No
Difficulty in opening or closing the mouth? …….. Yes No
Difficulty chewing on either side of mouth? ……. Yes No
Headaches, neck aches, or shoulder aches? ……... Yes No
Sore muscles (neck, shoulders)? …… Yes No

Please **Circle** the following dental values **most important** to you and **Underline** the **least important**:

Esthetics Comfort Longevity Function
Long-term cost effectiveness

Please Circle the most important feature(s) in your smile that you would like to change? Color Shape Alignment Length Gaps Gum display Nothing, I'm Happy
Other _____

Would you like your smile analyzed? …… Yes No
If yes, is there a spouse or significant other you want to include in our discussion? …….. Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe _____

Musculoskeletal/Occlusal Signs Exam Form

Name _____

Date _____ Age _____

SYMPTOMS

- ☐ Headaches
- ☐ TMJ Pain
- ☐ TMJ Noise
- ☐ Limited Opening
- ☐ Ear Congestion
- ☐ Vertigo (Dizziness)
- ☐ Tinnitus (Ringing in the Ears)
- ☐ Dysphagia (Difficulty Swallowing)
- ☐ Loose Teeth
- ☐ Clenching / Bruxing
- ☐ Facial Pain (Nonspecific)
- ☐ Tender, Sensitive Teeth (Percussion)
- ☐ Difficulty Chewing
- ☐ Cervical Pain
- ☐ Postural Problems
- ☐ Paresthesia of Fingertips (Tingling)
- ☐ Thermal Sensitivity (Hot and Cold)
- ☐ Trigeminal Neuralgia
- ☐ Bell's Palsy
- ☐ Nervousness / Insomnia

SIGNS (Extra-oral)

- ☐ Facial Asymmetry Bilaterally
- ☐ Short Lower Third of the Face
- ☐ Chelitis
- ☐ Abnormal Lip Posture
- ☐ Deep Mentalis Crease
- ☐ Dished-Out or Flat Labial Profile
- ☐ Facial Edema
- ☐ Mandibular Torticollis
- ☐ Cervical Torticollis
- ☐ Forward Head Posture (Lordosis)
- ☐ Elongated Lower Face (Steep Mandibular Angle)
- ☐ Speech Abnormalities

SIGNS (Intra-oral)

- ☐ Crowded Lower Anteriors
- ☐ Wear of Lower Anterior Teeth
- ☐ Lingual Inclination of Lower Anteriors
- ☐ Lingual Inclination of Upper Anteriors (Div. II Occlusion)
- ☐ Bicuspid Drop Off
- ☐ Depressed Curve of Spee
- ☐ Lingually Tipped Lower Posteriors
- ☐ Narrow Mandibular Arch
- ☐ Narrow Maxillary Arch (High Palatal Vault)
- ☐ Midline Discrepancy
- ☐ Malrelated Dental Arches
- ☐ Tooth Mobility
- ☐ Flared Upper Anterior Teeth
- ☐ Facets
- ☐ Cervical Erosion (Abfractions)
- ☐ Locked Upper Buccal Cusps
- ☐ Fractured Cusps (Particularly Cl. I & II Non-functional Cusps)
- ☐ Chipped Anterior Teeth
- ☐ Loss of Molars
- ☐ Open Interproximal Contacts
- ☐ Unexplained Gingival Inflammation and Hypertrophy
- ☐ Crossbite
- ☐ Anterior Open Bite
- ☐ Anterior Tongue Thrust
- ☐ Lateral Tongue Thrust
- ☐ Scalloping of the Lateral Border of the Tongue

_____

_____

_____

_____

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name		Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender Male ○ Female ○	Neck Size +2 Male ≥16.5 +2 Female≥15.0
Height	Feet / Inches		**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following 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 mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
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	○	○	○	○

Epworth Score TOTAL the values from all 8 questions. If 11 or less Score = 0 If 12 or more Score = 2

Score

Frequency	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code / Phone Number	**Total all 6 boxes from above** If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	Point Total