Date: _____

Patient Information

Patient Name: _____
(Last) (First) (Middle Initial)

Sex: M/F Date of Birth: _____ SSN#: _____ Marital Status: _____

Home Telephone: _____ Cell Phone: _____ Work: _____

Home Address: _____
(Street or P.O Box)

_____
(City) (State) (Zip Code)

Patient's Employer: _____ *Email Address*: _____

Emergency Contact Name: _____ Phone#: _____

Spouse's Name: _____Phone #: _____

Name of nearest relative/friend not living with you: _____Phone #: _____

How did you hear about our office? _____

Billing Information

Person Responsible for Bill: _____
(Last) (First) (Middle Initial)

Responsible Party's Home Telephone: _____ Cell: _____

SSN#: _____ Date of Birth: _____

Responsible Party's Address: _____
(Street or P.O Box)

_____
(City) (State) (Zip Code)

Responsible Party's Employer: _____Business Telephone: _____

Insurance Information

As a courtesy, we will accept payment of benefits directly from your insurance company and file with your secondary insurance if needed. No refunds are issued until both insurance companies have settled claim(s), and our office has received full payment of benefits. Please fill out accurately and completely. The part of our fee that is not covered by insurance is due at the time of treatment.

Is insured a current patient? Y/N

Name of Insured: _____
(Last) (First) (Middle Initial)

Employer: _____SSN#: _____Date of Birth: _____

Name of Insurance Company: _____

Group number: _____Telephone Number of Insurance Company: _____

_____***Initials*** ***CANCELLATION POLICY***: *As a courtesy to other patients, all cancellations must be made* ***24 hours*** *in advance of any scheduled appointments. If cancellations occur after this time, your account may be charged a cancellation fee. If you do not show for your scheduled appointment, your account may be charge a* ***"No-Show"*** *fee of $50.00 or more.* ***972.772.4000***

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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 medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Family physicians name: _____
Address:_____ Phone:_____
Are you under any other physician's/specialist's care now? ☐ Yes ☐ No
Their Name(s):_____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
Have you had an orthopedic total 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? ☐ Nursing? ☐ Taking Oral Contraceptives?
Are you previously or currently taking Bone metabolism medications? ☐ Yes ☐ No (Examples: Actonel, Zometa, Boniva, Fosamax):_____
_____
Please list all medications you are currently taking: _____
_____
_____

Are you allergic to any of the following? **(Please Circle)**

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other: Please List _____

Do you have or have had, any of the following? **(Please Circle)**

AIDS/HIV Positive	Chest Pain	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack/Failure	Low Blood Pressure	Spinal Bifida
Arthritis/Gout	Diabetes	Heart Murmur*	Lung Disease	Stomach/Intestinal Disease
Artificial Heart Valve*	Drug Addiction	Heart Pace Maker*	Mitral Valve Prolapse*	Stroke
Artificial Joint*	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy/Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B/C	Radiation Treatments	Tuberculosis
Breathing problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors/Growth
Bruise Easily	Fainting Spells/ Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives/Rash	Rheumatic Fever*	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

****conditions may require medication***

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No
Have you ever had any serious illness not listed above: ☐ Yes ☐ No ☐ N/A: _____

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 the 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

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Dental History

- When was the last time you went to a dentist for treatment? _____
- What was done at that time? _____
- What is the reason for your visit today? _____
- Have you ever been treated for periodontal disease? ☐ Yes ☐ No
- Have you had braces before? ☐ Yes ☐ No
- Does dental treatment make you nervous? ☐ Yes ☐ No
- Have you had an unpleasant dental experience? ☐ Yes ☐ No
- How often do you floss? _____
- What type of toothbrush do you use? (circle one) Soft Medium Hard Electric
- What other cleaning aids, devices or rinses do you use? _____

Do you experience any of the following?

- Bleeding or sore gums ☐ Yes ☐ No
- Bad breath/ unpleasant taste ☐ Yes ☐ No
- Tingling or burning tongue or lips ☐ Yes ☐ No
- Swelling or lumps in mouth ☐ Yes ☐ No
- Sores in mouth ☐ Yes ☐ No
- Food trapping between teeth ☐ Yes ☐ No
- Trouble swallowing without water ☐ Yes ☐ No
- Loose teeth ☐ Yes ☐ No
- Sensitive to hot ☐ Yes ☐ No
- Sensitive to cold ☐ Yes ☐ No
- Sensitive to sweets ☐ Yes ☐ No
- Clicking or popping jaw ☐ Yes ☐ No
- Frequent headaches ☐ Yes ☐ No
- Grinding or clenching ☐ Yes ☐ No

Smile Evaluation

	Yes	No
Are you self-conscious when you smile in front of other people or in pictures?	☐	☐
Do you ever cover your smile with your hand?	☐	☐
Do you have old filling or dental work that you don't like looking at?	☐	☐
Do you wish your teeth were whiter?	☐	☐
Do you dislike the shape of your teeth?	☐	☐
Do you have spaces between your teeth that you don't like?	☐	☐
Do you wish your teeth were straighter?	☐	☐
Are you unhappy with crowded or crooked teeth?	☐	☐

If you could wave a "magic wand" and change the appearance of your smile, how would you like it to look?

_____

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ORAL CANCER

Oral Cancer is on the rise, and last year 34,000 Americans were diagnosed with oral or pharyngeal cancer. On average it will cause over 8,000 deaths, killing 1 person per hour, 24 hours a day. Of those 34,000 newly diagnosed individuals, only half will survive 5 years. The death rate of oral cancer is higher than that of other cancers which we hear about routinely such as cervical cancer, Hodgkin's lymphoma, laryngeal cancer, cancer of the testes, even in skin cancer.

The diagnosis of oral cancer is also directly related to the human papilloma virus, affecting 50% of those diagnosed with HPV. HPV has the potential to cause an abnormal growth on a particular part of your body including lesions in your mouth and upper respiratory system.

The alarming mortality rate associated with this disease is due to the lack of early detection. If oral cancer is detected early it is completely treatable.

The good news is we can detect the early signs of oral cancer with a Velscope oral cancer screening today. It is pain-free and only takes a few minutes. It is the best tool we have to help detect the early signs of oral cancer. The cost for this service is $35 and may be covered by your insurance company. Please initial below:

_____ **I have been informed regarding the risk of oral cancer and I wish to have the Velscope oral cancer screening today.**

_____ **I have been informed regarding the risk of oral cancer but I do NOT wish to have the Velscope oral cancer screening today. I assume all risk associated with the unforeseen diagnoses of oral cancer.**

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SLEEP EVALUATION/CLINICALS

Date of Office Visit: _____

Patient Name: _____ Date of Birth: _____/_____/_____

Gender: M _____ F _____ Height: _____ Weight: _____ Blood Pressure: _____

Please check any of the following you may have:

☐ Morning Headaches	☐ Heart Disease	☐ Stroke	☐ Diabetes
☐ Frequent Urination at Night	☐ ADD/ADHD	☐ Depression	☐ Hypertension
☐ Erectile Dysfunction	☐ Atrial Fibrillation	☐ Overweight	☐ Heart Failure
☐ Low Testosterone	☐ Renal Failure	☐ Fibromyalgia	☐ GERD
☐ Grinding Teeth (Bruxism)	☐ Restless Legs (RLS)	☐ Memory Loss	☐ COPD

Please check Yes or No to the following questions:

1. Do you snore *or* have been told that you snore?	☐ YES	☐ NO
2. Do you often feel tired, fatigued, or sleepy during the daytime?	☐ YES	☐ NO
3. Has anyone observed you stop breathing or gasp for air during your sleep?	☐ YES	☐ NO
4. Do you have or are you being treated for high blood pressure?	☐ YES	☐ NO

If you answered Yes to 2 or more of the above, please continue:

Epworth Sleepiness Scale	Never doze off	Slight chance of dozing	Moderate chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0 ☐	1 ☐	2 ☐	3 ☐
2. Do you get sleepy, or doze off, while watching TV?	0 ☐	1 ☐	2 ☐	3 ☐
3. While sitting or inactive in a public place?	0 ☐	1 ☐	2 ☐	3 ☐
4. As a passenger in a car for an hour without a break?	0 ☐	1 ☐	2 ☐	3 ☐
5. Lying down to rest in the afternoon?	0 ☐	1 ☐	2 ☐	3 ☐
6. Sitting and talking to someone?	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 at a traffic light?	0 ☐	1 ☐	2 ☐	3 ☐
			Total Score	

Have you ever been diagnosed with Sleep Apnea?	☐ YES	☐ NO
Are you currently using CPAP? (or any other apnea/snoring device)	☐ YES	☐ NO
Are you currently taking any sleeping aids (prescribed or OTC)?	☐ YES	☐ NO
Are you currently taking any prescribed pain medications?	☐ YES	☐ NO

Untreated Sleep Disorders are related to many health *and* financial complications:

*Diabetes *Premature death *5X the risk of heart attack *2X the risk of stroke *Weight gain *6X the risk of a serious automobile accident *Increased risk of cancer *Hypertension *Depression *Erectile dysfunction *Daytime fatigue *ADHD *GERD *Decreased job performance *RLS/PLM *Increased cost of healthcare *Chronic/migraine headaches *Post-surgical complications/death *Chronic pain *Weakened immune system *Renal failure *Heart disease

Healthcare Provider *Signature/Initials** _____

**To be filed for reference and review in patient's chart notes*

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Rockwall Family Dentistry Office and Financial Policies

This is an outline of our office financial policies. We ask that you provide any/all insurance information to us upon arrival of your first visit. While we will do our very best to outline your insurance plan to you***, it is ultimately your responsibility to know your insurance plan benefits and restrictions*.** Based upon the information given to us by your insurance plan, we will ask for co-payments accordingly. It is important to remember that your insurance policy is a contract ***between you and your insurance company***. We will do everything possible to assist you in getting your claim paid: however, all charges incurred for your dental treatment are ***your sole financial responsibility***. Your co-payments are an estimate only. The quotes given to our office by your insurance company are merely that. ***They are not a guarantee of payment to us***. We ask that you pay your co-payment, deductible, or any balances at the time services are rendered. If you are unable to pay your estimated portion for that time, we ask that you make prior financial arrangements with our billing representative or through our other payment option Care Credit.

If you do not have dental insurance, by signing this statement you acknowledge that you understand that you are responsible for payment in full at the time services are rendered. If you have insurance, by signing this statement you acknowledge that your insurance company may pay less than the actual bill for services and that you are fully responsible for payment of your account. By signing this statement you agree to pay for all balances not paid by your insurance company and any legal fees incurred to enforce this statement. Finance charges can be applied to all amounts that are at least 30 days past due at the rate of 1.5% per month (18%annual rate). **If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection.** If during the admission or application process I have provided a cell phone number; I acknowledge that I may be contacted at that number for account servicing matters, including but not limited to collecting on my account should it become delinquent.

I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group benefits directly to Melina Cozby, DDS and Rockwall Family Dentistry P.A. I agree to give Rockwall Family Dentistry permission to contact me regarding appointments and/or treatment at the phone number provided. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I certify that the information I provided here is true and correct.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date: _____

Employee Signature: _____

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Photo Consent

I,_____, consent Rockwall Family
NAME (PLEASE PRINT)

Dentistry and Elite to be able to use photographs and/or videos of me for marketing and/or office advertising purposes, but not limited to only these purposes. For use on their (Rockwall Family Dentistry/Elite) social media tools which may include but not limited to their (Rockwall Family Dentistry/Elite) Facebook/ Websites/ Printed Materials.

Name (PLEASE PRINT):_____

Signature:_____ Date:_____

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Rockwall Family Dentistry – Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information

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Our legal duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, out legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made changes. Before we make significant change in our privacy practices, we will change this notice and make the new notice available.

Uses and disclosures of health information: We use and disclose health information about you for treatment payment, and healthcare operations.

***Patient Rights*: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request, unless we cannot practically do so. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $25 administration fee plus $5 per page for records.**

Rockwall Family Dentistry
3084 N Goliad St # 124,
Rockwall, TX 75087
(972) 772-4000