

Roswell Dental Care
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ROSWELL, GA 30076
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Roswell Dental Care Patient Information

Patient's Name _____ Today's date _____

Birthdate _____ Age _____ Gender _____ SSN _____

Address _____
_____ Marital Status _____

Referred by _____

Contact Information: Please provide at least 2 ways to be contacted.

Home _____ Cell _____ Work _____

Email _____

Employer _____

Employer's Address _____

Occupation _____ Length of employment _____

Spouse Information

Name _____ Date of Birth _____

Employer _____ Occupation _____

Cell Phone _____ Work Phone _____

Person Responsible for Account _____ Date of Birth _____

Employer _____ Occupation _____

Cell Phone _____ Work Phone _____

Emergency Contact _____ Relationship _____

Cell Phone _____ Work Phone _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company Name _____

Insurance Company Address _____ Phone _____

Insured's Name _____ **Date of Birth** _____ **SSN** _____

Insured's Employer _____ Address _____

Group Number _____ ID Number _____

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company Name _____

Insurance Company Address _____ Phone _____

Insured's Name _____ **Date of Birth** _____ **SSN** _____

Insured's Employer _____ Address _____

Group Number _____ ID Number _____

PATIENT HEALTH HISTORY

DATE: / /

NAME: _____ DATE OF BIRTH: _____

Please check any of the following conditions that apply to your health history *in the past 5 years*:

- | | |
|---------------------------------------------------|-------------------------------------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Intestinal Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Joint Replacement....Hip, Knee, Shoulder, etc. |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney or Bladder Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Chest Pain with Exertion | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Diabetes Type I; Type II | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pacemaker OR Defibrillator |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Easily Fatigued | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> History of Alcoholism | <input type="checkbox"/> STD's |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> X-ray Therapy to Head or Neck |

Have you been told that you need to Pre-Med before dental appointments? _____

Have you been treated for any other condition in the past year? _____

Have you been hospitalized in the past 5 years? If so, why? _____

Are you taking any medications to treat bone loss? _____

Have you ever been diagnosed with a sleep disorder? _____

Do you have a history of snoring? _____

Do you have trouble sleeping? _____

Do we have permission to use Nitrous Oxide (laughing gas)?	YES	NO
Do you feel self-conscious about your breath?	YES	NO
Do you ever feel a coating on your tongue?	YES	NO
Do you brush or scrape your tongue?	YES	NO
Are you interested in whiter teeth?	YES	NO
Do you wear contacts?	YES	NO

PLEASE LIST ALL CURRENT MEDICATIONS, PRESCRIPTION AND OVER THE COUNTER: (IF NONE, WRITE NONE)

PLEASE LIST DRUG ALLERGIES INCLUDING, BUT NOT LIMITED TO:

PENICILLIN	YES	NO	NOT SURE
ASPIRIN	YES	NO	NOT SURE
CODEINE	YES	NO	NOT SURE
LOCAL ANESTHETIC	YES	NO	NOT SURE
OTHER _____			

Email Address _____ Best contact phone # _____

Home mailing address (if changed)

Epworth Sleepiness Scale

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting, inactive , in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

If your score is greater than 6 points then you are sleepy. If your score is more than 10 points you are very sleepy. If your score is more than 16 points you are dangerously sleepy. If your score doesn't improve after 2 weeks of 8 hours of sleep a night, it is recommended that you consult your doctor.

THORNTON SNORING SCALE

If you snore, it doesn't only affect you, depriving you of comfortable rest. It also affects others. The Thornton Snoring Scale can help you determine how your snoring may be influencing the people around you. Choose the most appropriate number for each situation. (Go to question #4, if you have no bed partner.)

<i>0</i>	<i>Never</i>	
<i>1</i>	<i>Infrequently</i>	<i>(1 night per week)</i>
<i>2</i>	<i>Frequently</i>	<i>(2-3 nights per week)</i>
<i>3</i>	<i>Most of the time</i>	<i>(4 or more nights per week)</i>

1. My snoring affects my relationship with my partner: _____
2. My snoring causes my partner to be irritable or tired: _____
3. My snoring requires us to sleep in separate rooms: _____
4. My snoring is loud: _____
5. My snoring affects people when I am sleeping away from home: _____

Your score: _____

Thornton scoring analysis:

If score is 5 or higher, patient should seek medical advice.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand that under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my health information. I understand these rights and understand that the Notice of Privacy Practices containing a description of the uses and disclosures of my health information is available for my review.

PATIENT NAME (PLEASE PRINT): _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

I have attempted to obtain the patient's signature in acknowledgement of this notice, but was unable to do so as documented below:

NAME: _____ DATE: _____

REASON: _____

INSURANCE AND FINANCIAL POLICY AND AGREEMENT

PATIENT NAME _____

DATE OF BIRTH _____

Payment for services is expected at the time of service unless other arrangements have been made with our office.

As a courtesy, we will submit your insurance on your behalf. You will be responsible for any co-payments at the time of service.

We request that you pay your pre-determined patient portion at the time of service. When your insurance company pays us, any remaining balance will be your responsibility.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

I understand I am responsible for any financial obligation for treatment on myself or aforementioned patient.

I understand a credit verification can be requested if treatment is financed.

I understand a fee will be assessed for recovery if I fail to meet my financial obligation.

I affirm that the information I have given today is correct to the best of my knowledge and I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.

PRINT NAME: _____

SIGNATURE: _____ Date: _____

ROSWELL DENTAL CARE CANCELLATION POLICY

Broken appointments and last minute cancellations, leave time on our schedule that could have been used by another patient, had we known ahead of time. We make every effort to inform you of our appointments by using text messages, phone calls and emails. Unless you have an emergency or illness, we ask for at least a 24 hour notice, but preferably 48, for any changes in your appointment.

Our fee for no show appointments and last minute cancellations is \$75 per hour of time reserved. (2 hours =\$150.) We do this because your appointment is a contract with our office for time. Time lost can never be recovered and ultimately increases the cost of dentistry for all of our patients.

PLEASE SIGN BELOW TO CONFIRM YOUR ACKNOWLEDGEMENT OF THIS POLICY:

Signature: _____ Date: _____