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: / /

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

___Anemia
___Arthritis
___Asthma
___Cancer
___Chest Pain with Exertion
___Diabetes Type I; Type II
___Emphysema
___Epilepsy
___Fainting Spells
___Easily Fatigued
___Glaucoma
___Heart Disease
___Heart Murmur
___Heart Valve Replacement
___Hepatitis or Jaundice
___High Blood Pressure
___History of Alcoholism
___HIV Positive
___Intestinal Problems
___Joint Replacement....Hip, Knee, Shoulder, etc.
___Kidney or Bladder Disease
___Low Blood Pressure
___Nervous Disorder
___Osteoporosis
___Pacemaker OR Defibrillator
___Pregnant
___Prolonged Bleeding
___Rheumatic Fever
___Shortness of Breath
___Sleep Apnea
___Swollen Ankles
___Thyroid Disease
___Tobacco Use
___Tuberculosis
___STD's
___X-ray Therapy to Head or Neck

Have you been told that you need to Pre-Med before dental appointments?	YES	NO
Have you been treated for medical condition in the past year?	YES	NO
If so, what? _____		
Have you been hospitalized in the past 5 years?	YES	NO
If so, why? _____		
Are you taking any medications to treat bone loss?	YES	NO
Have you ever been diagnosed with a sleep disorder?	YES	NO
Do you have a history of snoring?	YES	NO
Do you have trouble sleeping?	YES	NO
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
Are you interested in Dysport (Botox) or facial fillers?	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	D/K
Aspirin	YES	NO	D/K
Codeine	YES	NO	D/K
Local Anesthetic	YES	NO	D/K
Cow Milk Protein	YES	NO	D/K

Other_____

Name of last dentist _____ Date of last dental exam _____

Date of last dental x-rays _____

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.)

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

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: _____