PATIENT INFORMATION

Date_____

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. _____ _____ _____
Last First Middle

☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed Age_____ Date of Birth _____

Home Address_____ City _____State_____Zip_____

Home Phone_____ Business Phone_____Ext._____ Cell Phone_____

Social Security #_____ Drivers License No._____

Employer_____ Occupation_____

Dental Insurance? ☐ Yes ☐ No If Yes, Group Carrier_____Group #_____

Spouse's Name_____ Person Responsible for the Bill_____

Has any member of your family been treated in our office? ☐ Yes ☐ No

*Names*_____

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

Call in case of emergency_____ Relationship_____ Phone_____ Cell Phone_____

Best time to call_____ Alternate_____

E-mail Address_____

MEDICAL HEALTH

Name and address of Physician_____

Physician's Phone # _____ Last complete physical? _____

Please check those conditions that now or ever pertained to you: Preferred Pharmacy_____Phone # _____

Overall General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Yes	No		Yes	No	
☐	☐	Are you currently under the care of a physician?	☐	☐	Eye, Ears, Nose and Throat Trouble
☐	☐	Rheumatic Fever	☐	☐	Glaucoma
☐	☐	Heart Murmur or Congenital Heart Disorder	☐	☐	Sinus Trouble, Hay Fever , Allergies
☐	☐	Have you ever been required to take any medication before a dental appointment?	☐	☐	Asthma
			☐	☐	Lung Problems, Tuberculosis or Emphysema
☐	☐	Angina or Heart Disease	☐	☐	Pneumonia
☐	☐	Heart Pacemaker	☐	☐	Joint Replacement
☐	☐	Heart Surgery / Artificial Heart Valve / Mitral Valve Prolapse	☐	☐	Convulsions or Epilepsy
☐	☐	Stroke / TIA	☐	☐	Bleeding Problems/Blood Transfusion/Hemophillia
☐	☐	Alzheimer's Disease	☐	☐	Blood Disease, Anemia, Sickle Cell
☐	☐	Abnormal Blood Pressure High/Low	☐	☐	AIDS or HIV+
☐	☐	Dizziness or Fainting Spells	☐	☐	Thyroid Disease
☐	☐	Circulatory Problems	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	Arthritis/Gout
☐	☐	Kidney Disease	☐	☐	Stomach/Intestinal Trouble, GERD
☐	☐	Jaundice or Liver Disease	☐	☐	Ulcers
☐	☐	Hepatitis A, B or C	☐	☐	Females Only: Are you pregnant or nursing?
☐	☐	Cancer	☐	☐	Females Only: Taking Oral Contraceptives?
☐	☐	Radiation or Chemotherapy	☐	☐	Do you use tobacco?
☐	☐	Severe Headaches/Migraines	☐	☐	History of Narcotic Abuse?
☐	☐	Continuous Positive Airway Pressure (CPAP) Treatment	☐	☐	Cold Sores/Fever Blisters
☐	☐	Snoring	☐	☐	Dry Mouth
☐	☐	Have you ever been hospitalized or had major surgery?			

Are you presently taking medication?

Yes ☐ No ☐ (If yes, please list and give reason for taking)

_____

_____

_____

_____

_____

_____

Are you Allergic or Sensitive to:

Yes	No	
☐	☐	Penicillin
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Demerol
☐	☐	Local Anesthetic like Novacaine
☐	☐	Latex
☐	☐	Other Drugs, Medications or Food (list) :

DENTAL HEALTH

On a scale of 1-10 (10 being the highest) what priority do you give your teeth? _____

Name and address of former Dentist _____

_____

_____

When was your last visit? _____ What was done at that time? _____

YES NO

- ☐ ☐ Are your teeth sensitive to sweets? Temperature?
- ☐ ☐ Have you been under regular care by a dentist?
- ☐ ☐ Do any of your teeth ache?
- ☐ ☐ Do your gums feel tender or swollen?
- ☐ ☐ Do you notice popping in your jaw?
- ☐ ☐ Have you had any teeth removed?
- ☐ ☐ Were there any complications involved afterwards?

YES NO

- ☐ ☐ Do you have any loose teeth?
- ☐ ☐ Do your gums bleed or have pain?
- ☐ ☐ Do you clench or grind your teeth?
- ☐ ☐ Have you had orthodontic treatment?
- ☐ ☐ Are you tense during dental visits?
- ☐ ☐ Are you happy with the appearance of your teeth?

Describe in your own words, your present dental problem:

_____

YES NO

- ☐ ☐ Are you deeply concerned about the finances required to return your mouth to excellent dental health?
- ☐ ☐ Do you want to learn to control dental disease and retain your teeth?
- ☐ ☐ Do you feel you will eventually wear artificial dentures?

Why did you leave your last Dentist?

_____

CONSENT FOR PROCEDURE

I certify that all the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic and nitrous oxide as indicated. I understand that I will be informed of any treatment changes as they occur. I will assume responsibility for fees associated with all procedures and all costs incurred in the collection of those fees.

Patient's (Parent's) Signature _____ Date _____

Doctor's Signature _____ Date _____

OFFICE USE

DATE	TOOTH	SERVICE RENDERED	CHARGE	PMT	BAL	

Valued Patient,

Due to OVERWHELMING REQUESTS from our patients for treatment to help alleviate sleep disorders like sleep apnea and snoring, we now offer an FDA approved oral appliance that eliminates or reduces sleep apnea and snoring.

Over 127 clinical trials have been performed confirming that oral appliances can eliminate or reduce sleep apnea. Universities including Harvard Medical School, UCLA School of Medicine, and University of Florida School of Medicine completed these clinical studies. Furthermore, the Department of Health reports that 80% of current CPAP users prefer an oral appliance to their current CPAP to reduce sleep apnea.

Obstructive sleep apnea can be a potentially life-threatening disease. Do you feel tired and sleepy even after a full night's sleep? Do you snore all night, are a mouth breather, get dry mouth, or feel fatigued the next day? If you have answered yes to any of these, then you are probably suffering from obstructive sleep apnea. Many are unaware that excessive snoring or sleep apnea is a serious health problem that can lead to heart disease, obesity, hypertension, stroke, diabetes and GERD if not treated in time. People with untreated sleep apnea are also 3-5 times more likely to develop cancer and are at an increased risk of dementia (due to hypoxia).

For these reasons we are now providing screenings for your convenience. If you feel you would benefit from this medical screening, then fill out the brief questionnaire below so we can better serve you.

The entire procedure should be covered by your medical insurance, provided you have met your deductible for the year.

Do you currently use a CPAP machine? **Y** **N**
Have you had a sleep study? **Y** **N**

Which of the following have you experienced?

- o Type 2 Diabetes
- o Daytime Sleepiness
- o Depression
- o Heavy Snoring
- o Difficulty Concentrating
- o Heart Disease
- o High Cholesterol
- o Stop Breathing While Sleeping
- o High Blood Pressure
- o History of Stroke
- o Restless Leg Syndrome

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations?
0 = Would never dose **2 = Moderate chance of dozing**
1 = Slight chance of dozing **3 = High chance of dozing**

Situation	**Score (0 to 3)**
Sitting and reading	
Watching television	
Sitting inactive in a public place (i.e. theater)	
As a car passenger for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopping for a few minutes in traffic	

DENTAL INSURANCE INFORMATION

Patient's name:_____ DOB:____/____/____

Home Phone:_____ Cell:_____ Work: _____

Address:_____City:_____ State:_____ Zip:_____

Relationship to the insured (please circle): Self Spouse Child Other

Student: YES NO Status: Full-time Part-time

Name of School:_____ City/State:_____

Primary Dental Insurance

Policy Holder:_____ SSN:_____ DOB:____/____/____

Home Phone:_____ Cell:_____ Work:_____

Address:_____City:_____ State:_____ Zip:_____

Employed by:_____ City:_____ State: _____

Insurance Company:_____ Group #:_____ Phone:_____

Secondary Dental Insurance

Policy Holder:_____ SSN:_____ DOB:____/____/____

Home Phone:_____ Cell:_____ Work:_____

Address:_____City:_____ State:_____ Zip:_____

Employed by:_____ City:_____ State: _____

Insurance Company:_____ Group #:_____ Phone:_____

I acknowledge that my insurance policy is a contract between the insured and the employer and accept responsibility for all fees not covered by the insurance company. Details of the insurance plan benefits and limitations are the responsibility of the policy holder and not Oviedo Premier Dental. I further give permission for Oviedo Premier Dental to file insurance claims and accept payments directly from the insurance company on my behalf.

Signature:_____ Date:_____

FINANCIAL FORM

Thank you for choosing us to provide your dental care. We are committed to providing you with the best possible care and service in a manner that will best suit your needs. We do not want financial considerations to be an obstacle to your care. It is for this reason that different options are available to you.

PATIENTS WITH INSURANCE: As a courtesy, we will complete and send dental insurance forms for you; however, your insurance policy is a contract between you and your insurance company. If payment has not been received from your insurance within 45 days, we will request payment in full from you. Any overpayment will be returned promptly. We expect payment in full within 15 days of insurance payment unless other arrangements have previously been made. While insurance benefits may be forthcoming, we are careful to make no assumptions about their amount. Knowing your insurance benefits is your responsibility; please contact your insurance company with any questions regarding coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

PATIENTS WITH OR WITHOUT INSURANCE: We are more than happy to discuss any financing and low monthly payments with you.

We accept cash as well as Visa, MasterCard, Discover, and American Express, but we do not accept personal checks. If an extended payment plan is desired, please ask us about zero percent financing.

Balances older than 30 days may be subject to interest charges of 1.5% per month or service charges. Any attorney or collection fees incurred due to delinquency in payment will also be charged to the patient.

I understand and accept responsibility for payment of all services rendered on my behalf and/or my dependents, which includes any amount not paid by insurance benefits. Failing to return to the office for completion of these procedures does not absolve me from being responsible for the full cost of that procedure. In the event that my account becomes delinquent, I am aware I will be responsible for any and all collection fees. I understand that this policy is subject to change. I understand that even if I do not sign this form, and consent to receive treatment, the above guidelines still apply.

Signature:_____ Date:_____

Notice of Privacy Practices Acknowledgment

Oviedo Premier Dental
1445 E. Mitchell Hammock Rd.
Oviedo, FL 32765
407-977-6464

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

If necessary my Protected Health Information may be released to the following person(s):

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

*If you would like anyone other than yourself to be able to call our office and discuss your account or dental information, you must print their name in the space provided above. This includes spouses and parents of children over 18.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason