

DATE _____

PATIENT INFORMATION

NAME _____ NICKNAME _____
First M.I. Last

SSN _____ SPOUSE NAME _____

BIRTHDATE _____ MALE FEMALE MARITAL STATUS S M D W

ADDRESS _____
Street **APT #** City State ZIP

MOBILE # _____ WORK # _____ E-MAIL _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DENTAL INSURANCE INFORMATION

Signature on file to file for insurance _____

INSURED'S NAME _____ **INSURED'S SSN** _____

INSURANCE COMPANY _____ POLICY ID# _____ **DOB** _____

INSURANCE COMPANY ADDRESS _____

INSURED'S EMPLOYER _____ ADDRESS _____

DO YOU HAVE DUAL DENTAL COVERAGE? YES NO IF YES:

INSURED'S NAME _____ INSURED'S SSN _____

INSURANCE COMPANY _____ GROUP # _____ DOB _____

INSURANCE COMPANY ADDRESS _____

CONCERNS AND COMMENTS

PLEASE LIST ANY CONCERNS OR COMMENTS YOU WANT THE DOCTOR TO KNOW ABOUT:

EMERGENCY INFORMATION

EMERGENCY CONTACT NAME _____ PHONE _____

ADDRESS _____
Street City State ZIP

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

PATIENT MEDICAL HISTORY

Medical Doctor's Name _____ Phone _____

YES NO Are you under any medical treatment now?

YES NO Have you had any major surgeries/operations? If yes, what? _____

YES NO Have you ever had a serious accident involving head injuries?

YES NO Have you had any adverse response to any drugs/materials including penicillin? If yes, what? _____

Has a physician ever informed you that you have:

YES NO Heart Ailment/Murmur

YES NO Mitral Valve Prolapse

YES NO Respiratory Disease

YES NO Diabetes

YES NO Rheumatic Fever

YES NO Arthritis

YES NO Tumors or Growths

YES NO Any Blood Disease

YES NO Any Venereal Disease

YES NO Aids

YES NO Thyroid Problems

YES NO Anemia

YES NO Stroke

YES NO Tuberculosis

YES NO Glaucoma

YES NO Any Kidney Disease

YES NO Any Stomach or Intestinal Disease

YES NO Yellow Jaundice or Hepatitis

Please list ANY drugs/medications you are currently taking _____

YES NO Are you generally in good health at this time?

YES NO Have any wounds healed slowly or presented other complications?

YES NO Do you have a history of fainting, seizures, convulsions, epilepsy, or headaches? If yes, circle.

YES NO Pregnant?..... YES NO Nursing?

Patient Dental History

YES NO Do you like your smile?

YES NO Do you have pain in or near your ears?

YES NO Does your jaw click or do you have difficulty chewing?

YES NO Do you have any unhealed injuries or inflamed areas in or around your mouth?

Have you experienced:

YES NO Any growth or sore spots in your mouth?

YES NO Clenching or grinding teeth?..... YES NO Bite lips or cheeks frequently?

YES NO Have you ever had novocaine anesthetic? List adverse reactions: _____

YES NO Difficult extractions in the past?..... YES NO Prolonged bleeding as a result?

YES NO Bleeding gums or Periodontal Therapy?

PATIENT/GUARDIAN SIGNATURE _____

DATE _____

FINANCIAL POLICIES

FORMS OF PAYMENT ACCEPTED: CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, CARE CREDIT (WAC)

1. ALL FEES ARE DUE THE DAY SERVICES ARE RENDERED.
2. CARE CREDIT IS A CREDIT CARD YOU APPLY FOR AT OUR OFFICE. DEPENDING ON THE AMOUNT YOU MAY BE ELIGIBLE FOR A 6 OR 12 MONTH INTEREST FREE PERIOD.

IF YOU ARE SENT TO COLLECTION, YOU WILL BE CHARGED THE COLLECTION AGENCY FEES ON TOP OF THE OUTSTANDING BALANCE YOU HAVE WITH COLONIALTOWN DENTAL..

*****3. NO SHOW OR CANCELLATION OF AN APPOINTMENT POLICY: WE CHARGE A \$40.00 FEE FOR MISSING AN APPOINTMENT WITHOUT CALLING 24 HOURS IN ADVANCE, OR NOT SHOWING UP AT ALL. THE \$40.00 WILL BE CHARGED TO YOUR ACCOUNT THE DAY THE APPOINTMENT IS MISSED.**

4. REGARDING INSURANCE:WE DO NOT CALL YOUR INSURANCE COMPANY. WE WILL ACCEPT ASSIGNMENT OF INSURANCE BENEFITS. HOWEVER, WE DO REQUIRE YOUR DEDUCTIBLE (WHEN IT HAS NOT BEEN MET) AND CO-PAYMENT TO BE PAID AT THE TIME SERVICES ARE RENDERED.

PLEASE NOTE IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN LIMITATIONS, (WHAT IS AND ISN'T COVERED, YOUR PERCENTAGES AND ANNUAL MAXIMUM), THIS IS YOUR RESPONSIBILITY. YOUR ACCOUNT BALANCE IS YOUR RESPONSIBILITY WHETHER YOU INSURANCE PAYS OR NOT. IF YOUR INSURANCE COMPANY HAS NOT PAID YOUR ACCOUNT IN FULL WITHIN 60 DAYS, ANY REMAINING BALANCE WILL BE DUE BY THE RESPONSIBLE PARTY.

5. WEEKEND, HOLIDAY OR EMERGENCY VISITS WILL BE CHARGED AN ADDITIONAL \$85.00

THANK YOU FOR UNDERSTANDING OUR POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THE POLICY.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

Notice of Privacy Practices

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If your dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request confidential communications from us by alternative means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we may have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the Privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name			Tally ARES Risk Points
Weight	Pounds	Age	Years	Gender Male <input type="radio"/> Female <input type="radio"/>		
Height	Feet	Inches	Neck Size	Inches		Score <input style="width: 40px; height: 20px;" type="text"/>
Date of Birth	Month	Day	Year	ID Number	Optional	

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

Have you been diagnosed or treated for any of the following conditions?						Co-morbidities +1 for each Yes response
High blood pressure	Yes <input type="radio"/>	No <input type="radio"/>	Stroke	Yes <input type="radio"/>	No <input type="radio"/>	
Heart disease	Yes <input type="radio"/>	No <input type="radio"/>	Depression	Yes <input type="radio"/>	No <input type="radio"/>	Do not assign any points for these eight responses
Diabetes	Yes <input type="radio"/>	No <input type="radio"/>	Sleep apnea	Yes <input type="radio"/>	No <input type="radio"/>	
Lung disease	Yes <input type="radio"/>	No <input type="radio"/>	Nasal oxygen use	Yes <input type="radio"/>	No <input type="radio"/>	
Insomnia	Yes <input type="radio"/>	No <input type="radio"/>	Restless leg syndrome	Yes <input type="radio"/>	No <input type="radio"/>	
Narcolepsy	Yes <input type="radio"/>	No <input type="radio"/>	Morning Headaches	Yes <input type="radio"/>	No <input type="radio"/>	
Sleeping Medication	Yes <input type="radio"/>	No <input type="radio"/>	Pain Medication e.g., vicodin, oxycontin	Yes <input type="radio"/>	No <input type="radio"/>	

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)					Epworth Score TOTAL the values from all 8 questions. If 11 or less Score = 0 If 12 or more Score = 2
0 = would never doze	1 = slight chance of dozing	2 = moderate chance of dozing	3 = high chance of dozing		
Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Score <input style="width: 40px; height: 20px;" type="text"/>
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sitting, inactive, in a public place (theater, meeting, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
As a passenger in a car for an hour without a break	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Lying down to rest in the afternoon when circumstances permit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sitting and talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sitting quietly after lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Frequency	0 - 1 times/week	1 - 2 times/week	3 - 4 times/week	5 - 7 times/week	Assign points for each of the first three responses <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/>
On average in the past month, how often have you snored or been told that you snored?					
Never <input type="radio"/>	Rarely <input type="radio"/> -1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> -3	Almost always <input type="radio"/> +4	
Do you wake up choking or gasping?					
Never <input type="radio"/>	Rarely <input type="radio"/> -1	Sometimes <input type="radio"/> +2	Frequently <input type="radio"/> -3	Almost always <input type="radio"/> +4	
Have you been told that you stop breathing in your sleep or wake up choking or gasping?					
Never <input type="radio"/>	Rarely <input type="radio"/> +1	Sometimes <input type="radio"/> -2	Frequently <input type="radio"/> +3	Almost always <input type="radio"/> +4	
Do you have problems keeping your legs still at night or need to move them to feel comfortable?					
Never <input type="radio"/>	Rarely <input type="radio"/>	Sometimes <input type="radio"/>	Frequently <input type="radio"/>	Almost always <input type="radio"/>	

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 <input style="width: 40px; height: 20px;" type="text"/>
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