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 ○ Female ○	Neck Size +2 Male ≥16.5 +2 Female≥15.0
Height	Feet / Inches		**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

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

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○	Co-morbidities +1 for each Yes response
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○	Score
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○	
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○	Do not assign any points for these eight responses
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○	
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○	
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○	

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)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions, If 11 or less **Score = 0** If 12 or more **Score = 2**

Score

Frequency	**0 - 1 times/week**	**1 - 2 times/week**	**3 - 4 times/week**	**5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

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**