Patient Information

Date _____ ☐Male ☐Female ☐Married ☐Single ☐Divorced ☐Separated ☐Student

Last Name _____ First Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

E-mail Address _____ Social Security # _____ Date of Birth _____

Home # _____ Work # _____ Cell # _____

Employer _____ Phone # _____

If patient is a minor, give parents or guardian's name _____

Name of nearest relative not living with you _____

Complete Address _____ Phone # _____

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

☐Yellow Pages ☐Location ☐Money Mailers ☐1-800 Dentist ☐News Paper ☐Other _____

Responsible Party Information

Last Name _____ First Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Previous Address (if less than 3 yrs.) _____

Social Security # _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Address _____ Phone # _____

Spouse Information

Last Name _____ First Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Social Security # _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Address _____ Phone # _____

Dental Insurance Information

Primary Dental Insurance	Secondary Dental Insurance
Insured's Name _____	Insured's Name _____
Insured's Date of Birth _____	Insured's Date of Birth _____
Insured's Phone # _____	Insured's Phone # _____
Insured's Social Security # _____	Insured's Social Security # _____
Insurance Company _____	Insurance Company _____
Company Address _____	Company Address _____
_____	_____
Insurance Company Phone # _____	Insurance Company Phone # _____
Insured's Employer _____	Insured's Employer _____

Dental Information

Do your gums bleed when you brush? ☐Yes ☐No

Are your teeth sensitive to heat or cold? ☐Yes ☐No

Are your teeth sensitive to Pressure? ☐Yes ☐No

Do you have a fear of the dentist? ☐Yes ☐No

Do you grind or clench your teeth? ☐Yes ☐No

Have you had your teeth bleached before? ☐Yes ☐No

How do you feel about the appearance of your teeth? Do you: ☐Love them ☐Accept them ☐Want to change them

How do you feel about the appearance of your smile? Do you: ☐Love it ☐Accept it ☐Want to change it

Date of Last Examination _____ What was done at that time? _____

Are you interested in using Nitrous Oxide (Laughing Gas) ..... ☐Yes ☐No

PLEASE COMPLETE THE INFORMATION ON THE BACK PAGE

Medical History Information

Patient Name: _____

1. Describe your current dental problem(s) _____
2. Are you having pain or discomfort at this time? ..... Yes No
3. Have you been a patient in the hospital during the past two years? ..... Yes No
4. Have you been under the care of a medical doctor during the past two years? ..... Yes No

Physician's Name_____ Phone Number _____
Address_____

5. Have you taken any medication or drugs in the past two years?..... Yes No
6. Are you now taking any medication or drugs? (includes medication for pain, recreational drugs, and hormones) ..... Yes No If yes, please list:_____
7. Are you currently taking any type of Herbal Supplements? ..... Yes No
If yes, please list:_____
8. Are you sensitive or allergic to any medication or anesthetics? ..... Yes No
If yes, please list:_____
9. Have you ever taken the diet drug Phen-Phen?..... Yes No
10. Indicate which of the following you have had or have at the present. Check "yes" or "no" for each item.

Heart Failure	Yes	No	*Artificial Joints (hip, knee, etc.)	Yes	No	Hepatitis B (serum)	Yes	No
Heart Disease or Attack	Yes	No	Kidney Trouble	Yes	No	Hepatitis C	Yes	No
Angina Pectoris	Yes	No	Ulcers	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Diabetes	Yes	No	A.I.D.S.	Yes	No
*Heart Murmur	Yes	No	Thyroid Problems	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
Arteriosclerosis	Yes	No	Cancer	Yes	No	Hemophilia	Yes	No
*Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Anemia	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
*Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Heart Surgery	Yes	No	Asthma	Yes	No	Liver Disease	Yes	No
*Rheumatic Fever	Yes	No	Hay Fever	Yes	No	Yellow Jaundice	Yes	No
Arthritis	Yes	No	Allergies or Hives	Yes	No	Epilepsy or Seizures	Yes	No
Rheumatism	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Cortisone Medicine	Yes	No	Radiation Therapy	Yes	No	Nervousness	Yes	No
Drug Addiction	Yes	No	Chemotherapy	Yes	No	Tumors	Yes	No
Stroke	Yes	No	Hepatitis A (infectious)	Yes	No	Developmentally Disabled	Yes	No
Low Blood Pressure	Yes	No	Breathing Problems	Yes	No	Frequent Diarrhea	Yes	No
Blood Disease	Yes	No	Shortness of Breath	Yes	No	Excessive Thirst	Yes	No
Hypoglycemia	Yes	No	Pain in Jaw Joints	Yes	No	Alzheimer's Disease	Yes	No

11. Do your ankles swell during the day? ..... Yes No
12. Have you lost or gained more than 10 pounds in the past year?..... Yes No
13. Are you on a special diet? ..... Yes No
14. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
If yes, please list:_____
15. Do you use tobacco products? ..... Yes No
16. Do you use alcohol products? ..... Yes No

FOR WOMEN ONLY:

17. Are you pregnant? .....Yes No If yes, what month? _____ Are you nursing? ..... Yes No
18. Are you taking birth control pills? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

_____ _____
PATIENT SIGNATURE OR RESPONSIBLE PARTY **DATE**

Medical Review: Reviewed by:_____ Date_____

Medical History Update by Patient: Initials_____ Date_____ Reviewed by:_____ Date_____
Medical History Update by Patient: Initials_____ Date_____ Reviewed by:_____ Date_____

Date

Sleep Health Questionnaire

EzSLEEP

Name ☐M ☐F Gender DOB

Address, City, State, Zip Weight Height

Cell Phone Alt. Phone Email

Medical Insurance Company ID# Group#

Section 1 - Patient Sleepiness Scale:

Step 1: Answer "Yes" or "No" for the following questions (circle Y or N). If you answer "yes" also circle the corresponding points in the column to the right.

Step 2: Total the points that you circled in the right column and record score in the space below.

Have you ever been told you stop breathing while asleep?	Y or N	8
Have you ever fallen asleep or nodded off while driving?	Y or N	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y or N	6
Do you feel excessively sleepy during the day?	Y or N	4
Do you snore or have you ever been told that you snore?	Y or N	4
Have you had weight gain and found it difficult to lose?	Y or N	2
Have you taken medication for, or been diagnosed with high blood pressure?	Y or N	2
Do you kick or jerk your legs while sleeping?	Y or N	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y or N	3
Do you wake up with headaches during the night or in the morning?	Y or N	3
Do you have trouble falling asleep?	Y or N	4
Do you have trouble staying asleep once you fall asleep?	Y or N	4
	Score	

Risk Level	Low	Moderate	High	Severe
Score	0-7	8-11	12-15	16+

Section 2 - Signs & Symptoms (Check all that apply):

☐ Hypertension ☐ Snoring ☐ Diabetes

☐ Depression ☐ Grind Teeth ☐ Acid Reflux

☐ Stroke/Heart Disease ☐ Unrefreshed Sleep

☐ Family history of Snoring or Sleep Apnea

Section 3 - Sleep History (Check all that apply):

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No

Are you currently using a CPAP machine? ☐ Yes ☐ No

Do you use your CPAP less than 5 times a week? ☐ Yes ☐ No

Would you prefer an oral appliance? ☐ Yes ☐ No

CONSENT TO PROCEED

I authorize Dr. K. Don Bigelow, such associates and or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health, or the dental health of any minor and or individual for which I have responsibility. This includes arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical instruments.

I understand that the administration of local anesthetic may cause untoward reaction or side effects, which may include but are not limited to: bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely permanent numbness. Occasionally drops of local anesthetic may contact the eyes and facial tissue and cause temporary irritation. I understand that occasionally needles may break and could potentially require surgical removal.

I understand that as a part of the dental treatment, including preventative procedures such as cleanings and basic dentistry including filings of all types, teeth may remain sensitive or even quite possibly painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek, or the oral tissue to be inadvertently abraded or lacerated during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician, or hospital and may in rare cases, required bronchoscopy, or other procedures to ensure the safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis may result in complication of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results; which may or may not be achieved for my benefit, or the benefit of a minor or other individual I am responsible for. I acknowledge that the nature and purpose of the foregoing procedure have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature: _____ Date: _____

(Patient, Legal guardian, or authorized agent of patient)

Witness: _____ Date: _____

FINANCIAL, INSURANCE AND, CANCELLATION POLICIES

Thank you for choosing us as your dental care provider. We are anxious to serve you and are committed to providing the best possible care. Payment is due at time of treatment. Therefore financial responsibility on the part of each patient must be determined before treatment. All emergency services or any dental services performed without previous financial arrangements must be paid for in full at the time the services are rendered. In order to make your dental care financially comfortable, we offer the following financial options.

- **Payment in Full Courtesy.**

A prepayment courtesy of 7% will be subtracted from the total patient obligation if the patient obligation is **paid in full with cash.**

- **Outside Financing.**

Our office accepts Care Credit for patients to finance their dentistry. They have options ranging from 6 to 24 months interest free financing based on the amount financed. If you do not have Care Credit card we would be more than happy to help you apply for one here in the office.

- **No Dental Insurance Discount (20% with the Big Smiles Dental Plan).**

Patients without dental insurance will be given a 20% when they sign up for the Big Smiles Dental Plan (ask for details). This offer cannot be combined with the "Payment in Full Courtesy" listed above.

INSURANCE:

It is our pleasure to assist you in maximizing your insurance benefit by completing your claim forms. At the time of service we will ask you to pay your **estimated** co-payment. Please understand that this is only an **estimate**, and is based upon the information available to us. Insurance benefit coverage depends solely on what your employer wishes to purchase. Some plans cover as little as 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it means 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. The **financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office.** We will assist you in any way we can. Any amount owing after your insurance company has paid will be due from you upon receipt of our statement. If for any reason we have not received your insurance carrier's payment 90 days after the claim was submitted, the remaining balance will be due and payable by you. Any unpaid balance exceeding 60 days from the date of service will be assessed a fixed rate of 2% per month(24% per annum) unless previous financial arrangements have been made. Should the account be referred to an attorney or collection agency, I will pay all cost of collection, including up to 40% collection fee, as well as court costs and a reasonable attorney fee. I allow the below signature to be held as a signature on file for all insurance claims and/or telephone /mail/credit card payments.

OFFICE CANCELLATION POLICY:

We ask for at least a **48 hour advance notice for canceling or rescheduling an appointment**. Otherwise, a $75 fee per hour may be assessed to your account. Please note that all cancellation fees must be **paid prior to scheduling another appointment**. The treatment that is planned for you is specific to you. It is important that you keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to 3 people – the patient who missed the valuable time, the patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment. By signing the for below you agree to show up to your scheduled appointments on time, and acknowledge the 48 hour cancellation policy if there is a need to reschedule or cancel the appointment.

Patient's Signature _____ Date_____

Parent or Responsible Party _____ Relationship to Patient _____

WE ARE PLEASED TO HAVE YOU AS OUR PATIENT

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICIES AND AUTHORIZATION FOR SIGNATURE ON FILE

I consent to the disclosure of records and authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance may pay less than the actual bill for the services, and that I am financially responsible for payment in full of all accounts. By signing this statement I authorize the dentist and his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information to be submitted necessary. I grant permission to you or your asignee to telephone me at home or at the work place to discuss matters related to this form. I revoke all previous agreements to the contrary and agree to be responsible for payment of services. In the event of non-payment for dental services received, the undersigned agrees to pay all lawyer fees, court costs, and collection fees up to 50%, if turned over to a outside collection agency.

HIPAA PRIVACY: Acknowledgement of Receipt of Notice of Privacy Practices

A COPY OF OUR NOTICE OF PRIVACY PRACTICES IS AVAILABLE AT YOUR REQUEST.

I, _____ have had full opportunity to read and consider the consent form and notice of privacy practices, I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health and dental information to carry out treatment, payment activities and health care operations.

If you wish to grant a family member or other party the access to your personal information on file in our office please complete the following.

Personal representative's name: _____
Relationship to patient: _____

I certify that I have read this form and I agree to abide by the conditions outlined hereon. I attest to the accuracy of the information on this page.

_____ _____

Signature of Patient or Responsible Party Date