smile up DENTISTRY

PATIENT INFORMATION

DATE: ☐ NEW PATIENT ☐ UPDATE

PATIENT: FIRST LAST MI PREFERED TITLE

PREFERRED CONTACT METHOD: EMAIL CELL HM # TEXT (CIRCLE ONE)

☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

PATIENT DATE OF BIRTH: PATIENT SSN:

ADDRESS: ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

HOME:
CELL:
OTHER:
PAGER:
FAX:

E-MAIL:

REFERRAL? ☐ Yes ☐ No REFERRED BY:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP TELEPHONE NUMBER

EMPLOYMENT INFORMATION

EMPLOYER: OCCUPATION:

ADDRESS: ADDRESS LINE 1

CITY ST ZIP CODE

WORK:
CELL:
FAX:

E-MAIL:

INSURANCE INFORMATION

SUBSCRIBER: LAST FIRST MI PREFERRED TITLE

SUBSCRIBER DATE OF BIRTH: SUBSCRIBER SSN:

SUBSCRIBER EMPLOYER:

PATIENT RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY INSURANCE CARRIER:
Group/Policy No.: ID No:
Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:
Group/Policy No.: ID No:
Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

DENTAL HISTORY

☐Y☐N Are you currently having dental discomfort? If yes, explain: .....
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: .....
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N

MEDICAL HISTORY

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? .....
☐Y☐N Any serious illnesses/surgeries? .....
☐Y☐N Use tobacco in any form? If Yes, Type: .....
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

.....

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐PACEMAKER
☐OTHER – PLEASE LIST: .....
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐VENEREAL DISEASE

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐NONE

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐CODEINE
☐DAIRY
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS
☐OTHER – PLEASE LIST: .....

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (PLEASE LIST BELOW)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME	DOSAGE	REASON PRESCRIBED

PATIENT INFORMATION

Who can thank their visit today with us?

○ Drive / walk by

○ insurance company

○ Transfer from another office

○ Referral of the patient: _____

○ Search online

○ Mailer

○ Staff

○ Other: _____

Is there a problem or particular service that you would like to discuss with the doctor?

○ Toothache

○ Bad breath/bleeding gums

○ the wisdom teeth removal

○ Bridge/veneers/crowns

○ Partial, prosthesis, fin

○ Implants

○ chipped or cracked teeth

○ Invisalign / braces

APPOINTMENT REMINDERS

We will remind you of your next appointments using text, telephone calls and e-mail messages. Please make sure we have your current cell phone, phone number, or email address

Cell phone: _____

Phone #: _____

Email address: _____

PATIENT PHOTO RELEASE FORM

I _____, hereby authorize SmileUp Dentistry, or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing. (If declining this consent, leave blank)

Please initial one option:

_____I do not mind if my photographs are used in any of the above stated situations.
_____I only agree to have my teeth shown without any identifying features.

Signature: _____ Date: _____

SPECIAL OFFERS

□ I OPT IN to receive special offers via email or text messages

□ I OPT OUT to receive special offers by e-mail or text messages

FINANCIAL POLICY

We are privileged you have chosen us as your dental care provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to treatment. If you have any questions, please feel free to ask.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, and most major credit cards. There will be a $35.00 fee on all returned checks.

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and copayments as accurately as possible. Please understand that all treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and co-payments are due the day the treatment is rendered.

Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.** Once a payment is received on your claim, we will send you a bill for any remaining balance on your account. Credits issued can only be applied for further treatment.

At our discretion, any unpaid balance after 90 days will be sent to collections at which the patient is responsible for any fees associated with the collection of the balance.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

BROKEN APPOINTMENT POLICY

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion.

So that the dentist, our staff, and our patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment (24 hours advance notification), will result in a fee being charged. Depending on the situation the fees range from $50-$100. That charge which is in accordance with our dental office's broken appointment policy for all of our patients is to be paid within 30 days to prevent collection procedures. The patient/parent/legal guardian is responsible for the payment of the charge.

Please feel free to discuss this and other policies with our staff. Do not hesitate to call our office if you have any questions.

_____ _____

Signature **Date**

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Who Will Follow This Notice

This notice describes the privacy practices of SmileUp Dentistry. These privacy practices apply to our dental practice and to our staff, our dentists, hygienists and other health care professionals, and employees working at our offices.

Our Pledge Regarding Health Information

We understand that medical information about you and your health is personal. We are committed to protecting your health information. We create a record of the care and services you receive at our offices. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or kept by our dentists, hygienists and other staff. This notice will tell you about the ways we may use and disclose your health information. We also describe your rights and certain obligations we have concerning the use and disclosure of your health information.

We are required by law to:

Make sure that health information that identifies you is kept private;
Give you this notice of our legal duties and privacy practices with respect to health information about you; and
follow the terms of this notice that is currently in effect, as we may change it from time to time.

How We May Use and Disclose Your Health Information

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use your health information to provide you with dental treatment or services. We may disclose health information about you to dentists, dental assistants, hygienists, other dental office personal or other health care providers ho are involved in your treatment or care. For example, your dentist may need to disclose some of your health information to order tests or lab work to be performed at an outside laboratory or other outside health care provider, or your dentist may need to disclose your health information to people outside the office who may be involved in your dental or health care after you leave the dental office, such as family members, or clergy.

For Payment: We may use and disclose health information about your treatment and services to bill and collect from you, your insurance company or a third party payer. For example, we may need to give your dental/health insurance plan information so that it will pay us or reimburse you for dental services. We may also tell your health insurance plan about a treatment you are goin to receive to determine whether your plan will cover it.

For Health Care Operations: We may use and disclose your health information for office operations. Theses uses and disclosures are necessary to run our dental office and make sure that all of our patients receive quality care. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many of our patients to decide what additional services we should offer and what services are not needed. We may also disclose information to dentists, hygienists, dental assistants, and other personnel for review and learning purposes. We may also combine the health information we have with health information from other dental practices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment for treatment at our office.

Treatment Alternatives: We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Individual Involved in Your Care or Payment for Your Care: We may disclose your health information to a member of your family, your friend or another individual who is directly involved in your care and the disclosure is necessary for your welfare. The practice will limit health information disclosed to the family member, friend or other individual to health related signs and symptoms and to information designed to help you deal with your condition or treatment, including setting and changing appointments, receiving instructions for post-visit care or picking up treatment-related items. We may also disclose a limited amount of your health information to locate you or to locate or notify your family member or friend. We may also give information to someone who helps pay for your care. We will not make these disclosures to your friends and family if you tell us not to.

Business Associates: There are some services that we provide through contracts with business associates. We use an outside service for recall reminders and claim processing. When these services are contracted we may disclose your health care information to our business associate so that the associate can perform the job we have asked them to do. To protect your health information, we require the business associate to safeguard the privacy of your information.

As Required by Law and Law Enforcement: We will disclose health information about you when required to do so by federal, state or local law. We may release information if asked to do so by a law enforcement official.

To Avoid a Serious Threat to Health and Safety: We may use and disclose health information about you when necessary to prevent a serious threat and safety or the health and safety of the public or another person.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, inspections, and licensure.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute we may disclose health information about you in response to a court or administrative order.

Medical Examiner: We may release health information to a coroner, medical examiner, and funeral director.

Permission from you: Other uses and disclosures of health information not covered in the above categories will be made with your permission. You may give permission with a written consent or authorization. You may revoke permissions at any time. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care we provide.

Your Health Information Right
You have the following rights concerning health information we maintain about you:

Right to Inspect and Copy your Health Information: You have the right to inspect and copy your health information and to receive a written summary or explanation of your health information. If you make a request you will be provided the information and copy of records within 3 days after the administrative fee and authorization form are completed. We may deny your request in certain very limited circumstances.

Right to Ask for Changes in Health Information: If you feel that the health information we have about you is incorrect or incomplete, you may ask us to change or add to the information. You have the right to ask for a change or addition for as long as the information is kept by the office. You must give us a reason for your request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny your request. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health information in a certain way. For example, you can ask that we only contact you at work or by email. Your request must specify how you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Event if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Changes to this Notice
We reserve the right to change this notice and the revised or changed notice will be effective for health information we already have about you, as well as any information we receive in the future.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with our dental office or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. You will not be penalized for filling a complaint.

Acknowledgment of Receipt of Notice of Privacy Practices

TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read the notice of privacy practices before deciding whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent.

Right to Revoke: You will have the right to revoke this consent at any time by giving us a written notice of your revocation. Please understand that the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation.

SIGNATURE

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

Signature: _____ **Date:** _____

PATIENT/RELATIVE HIPPA CONSENT

I _____, understand that by signing this consent form, I am giving my consent to SmileUp Dentistry to disclose and discuss my protected health information to carry out the treatment, payment activities and health operations with the following family member:

Name:_____
Relationship:_____

Patient's Signature (Legal Guardian If the patient is a minor)

_____

REVOCATION OF CONSENT

I revoke my consent to use and disclose my protected health information for treatment, payment activities, and health operations.

I understand that the revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may refuse to treat or continue to treat me after I have revoked my consent.

Signature: _____ **Date:** _____

If this revocation of consent is signed by a Personal Representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign □ Communication barriers prohibited obtaining the acknowledgement □ An emergency situation prevented us from obtaining acknowledgement □ Other (please specify) : _____

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

Do you use a CPAP machine? _____

Do you snore? _____

Has anyone observed you stop breathing during your sleep? _____

How likely are you to doze 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.

Use the following scale to choose the **most appropriate number** for each situation:

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

It is important that you answer each question as best you can.

SITUATION	**CHANCE OF DOZING (0-3)**
Sitting and reading:	_____
Watching TV:	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting):	_____
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 a lunch without alcohol:	_____
In a car, while stopped for a few minutes in the traffic:	_____

THANK YOU FOR YOUR COOPERATION

Sleep, Breathing & Habit Questionnaire — Children & Adolescents

Full Name:	Age:	Date:

Please indicate if your child experiences or has experienced any of these symptoms below by using this scale to measure the severity of these symptoms.

0 - No Occurrence **1 - Occurs Rarely** **2 - Occurs 2 to 4 times per week** **3 - Occurs 5 to 7 times per week**

1. _____ Snoring
2. _____ Interrupted snoring where breathing stops
3. _____ Labored, difficult or loud breathing at night
4. _____ Gasping for air while sleeping
5. _____ Mouth breathes while sleeping
6. _____ Mouth breathes during day
7. _____ Restless sleep
8. _____ Grinds teeth while sleeping
9. _____ Talks in sleep
10. _____ Excessive sweating while sleeping
11. _____ Wakes up at night
12. _____ Wets the bed (currently)
13. _____ History of bed wetting
14. _____ Feels sleepy and/or irritable during the day
15. _____ Headaches
16. _____ Frequent throat infections
17. _____ Seasonal allergies
18. _____ Ear infections of history of ear infections
19. _____ Short attention span
20. _____ Trouble focusing
21. _____ Difficulty listening/ often interrupts
22. _____ Hyperactive
23. _____ ADD/ADHD
24. _____ Sensory Issues
25. _____ Struggles in math at school
26. _____ Struggles in reading at school
27. _____ Speech issues*
28. _____ Avoidance behavior towards food or certain types of food

*Speech Questionnaire - to be filled out only if #27 was indicated above

Please check all that apply

_____ Is it difficult to understand your child's speech?

_____ Difficult to understand over the phone?

_____ Nasal speech?

_____ Hoarseness?

_____ Other have difficulty understanding speech?

_____ Gets frustrated when people can't understand speech?

_____ Speech sounds abnormal?

_____ Sometimes omits consonants?

_____ Uses M, N, NG instead of P, V, S, Z sounds?

_____ Liquids and/or solids get into nasal area when eating or drinking?

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosed with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = (your weight in pounds X 703)

_____

(your height in inches X your height in inches)