Form 14-208F1

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

________________________________
{Please Print Name}

________________________________
{Signature}

________________________________
{Date}

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**For Office Use Only**

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We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

________________________________________________

________________________________________________

________________________________________________

| ________________________ | ________________________ |
| --- | --- |
| Employee Name | Office Name |
| ________________________ | ________________________ |
| Employee Signature | Date |

## PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)__________

Previous Dentist__________ Last Visit__________ Date of last cleaning__________

Reasons for changing dentists:__________

What problems have you had with past dental treatment?__________

Are you nervous about seeing a dentist? ❑ Yes! ❑ No If yes, please tell us why:__________

How often do you brush?__________ Do you floss? ❑ Yes ❑ No How often?__________

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straight.
Y N I want my teeth whiter.

What are your dental priorities?__________
*(e.g.: appearance, dental health, financial considerations, etc.)*

## PATIENTS MEDICAL HISTORY

I consider my health to be *(please check one)* ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you or have you had any of the following? *please circle Y for yes or N for no.*

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3 .Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: ❑ Hip ❑ Knee ❑ Other
16. Y N I smoke or use tobacco. If yes, how much per day?______ How many years?______
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year______Type of operation:__________ Year______Type of operation:__________

22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type____.
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis (Mono)
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Disease
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation Treatment
35. Y N History of Drug Addiction

*Doctor Notes Only:*

36. Y N AIDS
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

**WOMEN**

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

21. Y N Do you have any other medical problem or medical history NOT listed on this form?__________

Are you allergic to any of the following?
*Please circle Y for yes or N for no*

44. Y N Aspirin
45. Y N Ibuprofen
46. Y N Sulfa Drugs/Sulfites/Sulfides
47. Y N Penicillin
48. Y N Codeine
49. Y N Latex, Metals, Plastics
50. Y N Local Anesthetics (Novocaine)
51. Y N Other Medications - Which ones?__________

*Please list all medications you are currently taking:*

Medicine__________Condition__________
Medicine__________Condition__________
Medicine__________Condition__________
Medicine__________Condition__________
Physician's Name__________Phone__________
Address__________ Fax __________

**In the event of an emergency please contact:**

Name__________Relationship__________Phone __________
Name__________Relationship__________Phone __________

Initial medical/dental health reviewed by:

X__________ / ____/____ X__________ / ____/____
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X__________ / ____/____ X__________ / ____/____
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date

GETTING TO KNOW YOU AS OUR PATIENT

Date ________________________

# GETTING TO KNOW YOU AS OUR PATIENT

| PATIENT NAME | | | SOCIAL SECURITY NUMBER | | HOME PHONE ( ) |
|---|---|---|---|---|---|
| Home Address | | | City, State, Zip | | CELL PHONE ( ) |
| Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated | ❑ M ❑ F | Birthdate / / | | Drivers License and State | E-MAIL ADDRESS |

Primary Insurance Company ________________________ Group________________ Subscriber________________

Secondary Insurance Company ________________________ Group________________ Subscriber________________

**Please Note: Providing the above contact information (address, phone number, cell phone number and email address) gives MyDentist permission to contact you using the media indicated concerning appointments, newsletters and other business matters. We will not share your contact information.**

**Responsible Party**

| NAME | SOCIAL SECURITY NUMBER | HOME PHONE ( ) |
|---|---|---|
| Home Address | City, State, Zip | Birthdate / / |
| Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated | Relationship to Patient | Drivers License and State |
| Responsible Person's Employer | Occupation | Work Phone ( ) |
| Business Address | City | State Zip |
| **Spouse's Name** | Social Security Number | Birthdate / / |
| Spouse's Employer | Spouse's Occupation | Spouse's Work Phone ( ) |
| Spouse's Business Address | City | State Zip |

## How did you hear about our Office? (check only one)

Who selected this Office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

Where did you find the Phone Number to this Office? ________________________

❑ Referred by a friend ❑ Yellow Pages ❑ Relative ❑ Insurance Plan ❑ Welcome Wagon

❑ Other________________ ❑ TV/Radio Ad ❑ Newspaper Ad ❑ Direct Mailing ❑ Sign by Building

If you were referred, whom may we thank for referring you? ________________________

## CONSENT

•I will answer all health questions to the best of my knowledge ____________
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature Date Relationship to Patient

## TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.
As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

**Assignment of Insurance:** I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

**Signed**________________________________________ **Date**________________

**There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.**

# MyDentist

**Insurance Benefits, Medical Information Release and Financial Responsibility Agreement**

## INSURANCE

MyDentist is dedicated to helping you keep your smile healthy and beautiful for a lifetime. Our office will do everything possible to help you understand and make the most of your dental insurance benefits. As a courtesy, we will complete and submit dental insurance forms to your insurance company to achieve the maximum reimbursement to which you are entitled and will strive to make this happen as quickly as possible.

We can only estimate the amount your insurance company will pay toward each dental procedure and are not able to guarantee what your insurance company will pay. **By signing this agreement, you are indicating that you understand and agree that you are solely responsible for all fees, including those not paid by your insurance company.** We will file your insurance only under these terms.

In some cases, your insurance company may have a maximum allowable charge for a procedure. This maximum allowable charge, as determined by the insurance company, does not determine the fee you are charged for dental services and may be less than our quoted fee. By signing this agreement, you are indicating that you understand and agree that you are solely responsible for all fees, including those not paid by your insurance company.

In some cases, your insurance company may have a maximum yearly allowable. We will work with you to attempt to control your cost for the year to that amount, if requested. By signing this agreement, you are indicating that you understand and agree that you are solely responsible for all fees, including those not paid by your insurance company.

Payment for dental/medical services must be made when your treatment plan is accepted, or at the time treatment is provided, unless prior financial arrangements have been made.

By signing this agreement, you assign to MyDentist all payments for dental services rendered to you or your dependents. By signing this agreement, you are indicating that you understand and agree that you are solely responsible for all fees, including those not paid by your insurance company. These include any deductible amount, any amount that would be paid by co-insurance and insurance exclusions and/or limitations.

## RELEASE OF MEDICAL RECORDS

You hereby authorize MyDentist to release copies of any and all information in your dental/medical records to other dental/medical providers or insurance carriers as a part of, or result of your treatment and/or to any other organization for the sole purpose of obtaining payment for dental/medical services provided to or for you or your dependent/s.

You release MyDentist, its employees and all other persons caring for you at MyDentist from any liability connected with the use of these records or the information in them by anyone outside of MyDentist.

You understand that this release will remain valid until revoked in writing by you.

## FINANCIAL RESPONSIBILITY

By signing this agreement, you are indicating that you agree to the terms of this agreement, including being responsible for all legal fees, costs and an annual interest rate of 22% in the event that you breach this agreement. This agreement will be considered breached by you if MyDentist has not received payment in full within 30 days of your receipt of the final bill. In the event of breach of this agreement, all parties stipulate that Oklahoma County, OK will be the county of jurisdiction to hear any dispute arising hereto.

You have read, or had read to you, all of the above and understand all parts of this document.

Patient Signature: ____________________________________________ Date: ___________________

Custodial Parent or Legal Guardian must sign if Patient is a minor under the age of 18 or legally incapacitated.

Witness Signature: ____________________________________________ Date: ___________________

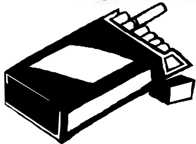
A photocopy of this authorization and assignment shall be considered as valid as the original. Rev 8/06

# Periodontal Risk Assessment Questionnaire

Name ______________________________ Date______________

## Tobacco Use

Tobacco use is the most significant risk factor for gum disease.



**Do you now or have you ever used the following:**

| | *Amounts per day* | *Used for how many years* | *If you quit, list what year* |
|---|---|---|---|
| ❑ Cigarette | ________ | ________ | ________ |
| ❑ Cigar | ________ | ________ | ________ |
| ❑ Pipe | ________ | ________ | ________ |
| ❑ Chewing | ________ | ________ | ________ |

**Blood Sugar**

## Diabetes

Gum disease is a common complication of diabetes. Untreated gum disease makes it harder for patients with diabetes to control their blood sugar.

**IF YOU ARE A PATIENT WHO HAS DIABETES:**

Is your diabetes under control? ❑ Yes ❑ No

Are you prone to diabetic complications? ❑ Yes ❑ No

How do you monitor your blood sugar? ______________________

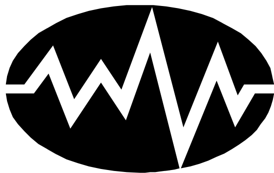
Who is your physician for diabetes? ______________________

**IF YOU ARE NOT A PATIENT WHO HAS DIABETES:**

Any family history of diabetes? ❑ Yes ❑ No

Have you had any of these warning signs of diabetes?

- ❑ frequent urination
- ❑ excessive thirst
- ❑ excessive hunger
- ❑ weakness and fatigue
- ❑ slow healing of cuts
- ❑ unexplained weight loss



## Heart Attack/Stroke

Untreated gum disease may increase your risk for heart attack or stroke.

**Do you have any risk factors for heart disease or stroke?**

- ❑ Family history of heart disease
- ❑ Tobacco use
- ❑ Obesity
- ❑ High cholesterol
- ❑ High blood pressure

*If you have any of these other risk factors it is especially important for you to always keep your gums as healthy as possible.*

## Medications

A side effect of some medications can cause changes in your gums.

**Are you taking or have you ever taken any of the following medication:**

❑ Antiseizure medications. (such as Dilantin®, Tegretol®, Phenobarbital, etc.)
❑ Yes ❑ No

If you answered yes, are you still taking the anti-seizure medication?
❑ Yes ❑ No

Other Medication:______________________

❑ Calcium Channel Blocker blood pressure medication. (such as Procardia®, Cardizem®, Norvasc®, Verapamil®, etc.)
Other:______________________

❑ Immunosuppressant therapy (such as Prednisone, Azathioprine, Cyclosporins, Corticosteriods (Asthma-Inhalers), etc.)
Other:______________________

## Family History/ Genetics

The tendency for gum disease to develop can be inherited.

**Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. your mother, father, or siblings):**
❑ Yes ❑ No

### Heart Murmur, Artificial joint prosthesis

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.

**Do you have a heart murmur or artificial joint?**

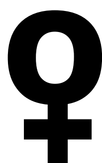
❑ Yes ❑ No

**If so, does your physician recommend antibiotics prior to dental visits?**

❑ Yes ❑ No

Name of physician? ______________________________

*If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.*



### Females

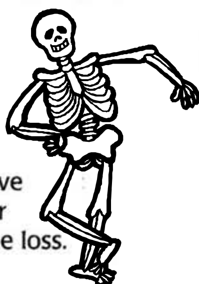
Females can be at increased risk for gum disease at different points in their lives.

**The following can adversely affect your gums. Please check all that apply:**

❑ Pregnant ❑ Nursing ❑ Menopause

❑ Taking birth control pills

❑ Infrequent care during previous pregnancies



### Women

Women with osteoporosis have a greater risk for periodontal bone loss.

**Females:**

**Do you take any of the following:**

❑ Estrogen Replacement Therapy/Hormone Replacement Therapy (such as Prempro®, Premarin®, Premphase®, Fosamax®, Actonel®, Evista®, Fortéo®, etc.)

Other: ______________________________________________

### Stress

High levels of stress can reduce your body's immune defense.

**Are you under a lot of stress?**

❑ Yes ❑ No

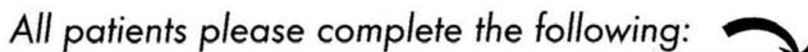
### Nutrition

Your diet has the potential to affect you periodontal health.

**Do you find it difficult to maintain a well-balanced diet?**

❑ Yes ❑ No

## *All patients please complete the following:*



**Have you noticed any of the following signs of gum disease?**

❑ Bleeding gums during toothbrushing

❑ Red, swollen or tender gums

❑ Gums that have pulled away from the teeth

❑ Persistent bad breath

❑ Pus between the teeth and gums

❑ Loose or separating teeth

❑ Change in the way your teeth fit together

❑ Food catching between teeth

**Is it important to keep your teeth for as long as possible?** ❑ Yes ❑ Not really

**If you have missing teeth, why have you not had them replaced?** ______________________________

______________________________________________

**Do you like the appearance of your smile?** ❑ Yes ❑ No

**Do you like the color of your teeth?** ❑ Yes ❑ No

**Do your teeth keep you from eating any specific food?** ❑ Yes ❑ No

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment**: We may use or disclose your health information to a dentist or other healthcare provider providing treatment to you.

**Payment**: We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization**: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writingat any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends**: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care**: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures.

In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays or other similar forms of health information.

**Marketing Health-Related Services**: We will not use your health information for marketing communications without your written authorization.

**Required by Law**: We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**PATIENT RIGHTS**

**Access**: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **You must make your request in writing.** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us as follows:


Gene Gay, Compliance Officer
**MyDentist**
PO Box 21840
Oklahoma City, OK 73156
***gene@mydentistinc.com***


If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

***Welcome to MyDentist!***
*Our goal is to provide you the best dental treatment possible. Please answer a few questions to help us better meet your dental needs.*

# SMILE! EVALUATION

NAME ______________________________ DATE ____________________

1. What do you want to accomplish during your appointment today?____________________
_____________________________________________
2. What could we do today to make this a positive experience for you? ____________________
_____________________________________________
3. If you could change one thing about your smile, what would it be? ____________________
_____________________________________________
4. Would you like your teeth to be whiter? ______________________________
5. Do you grind or clinch your teeth? If so, does your jaw hurt or give you headaches? __________
_____________________________________________
6. Do your gums bleed when you brush or floss?______________________________
7. Have you ever been treated for gum disease?______________________________
8. Have you been unhappy with any previous dental care? What happened? ____________________
_____________________________________________
9. How long has it been since you've seen a dentist?______________________________
10. Are you missing any teeth? ________ If so, how long have they been missing? ______________
11. Are you currently wearing any partials or dentures? ______ If so, how old are they? ___________
12. Do you have any crowns or bridges? _______ If so, how old are they? ____________________
13. How did you hear about MyDentist?______________________________

Doctor's/Hygienist's Notes:____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________

Rev. 11/2004

# Patient Sleep Questionnaire

Patient Age: ___________ Patient Gender: ___________

## Circle **Agree** or **Disagree** for each statement:

| | |
|---|---|
| **Agree / Disagree** | I have been told that I snore |
| **Agree / Disagree** | I have been told that I stop breathing when I sleep, although I may have no recollection of this. |
| **Agree / Disagree** | I am always sleepy during the day even though I sleep throughout the night. |
| **Agree / Disagree** | I have high blood pressure. |
| **Agree / Disagree** | I have been told that I sleep restlessly. I am always "tossing and turning" while asleep. |
| **Agree / Disagree** | I have difficulty sleeping 3 nights a week or more. |
| **Agree / Disagree** | I frequently awaken with headaches. |
| **Agree / Disagree** | I tend to fall asleep in inappropriate situations. |
| **Agree / Disagree** | Others and/or I have noticed a recent change in my personality. |
| **Agree / Disagree** | I am overweight. |

If you answered **Agree** to three or more of the above statements, you show symptoms of obstructive sleep apnea, a potentially life-threatening disorder. The dentist may request that you participate in a sleep study for further diagnostic testing. **If you have any questions, please do not hesitate to ask.**

______________________________ ______________________

**Patient Signature** **Date**