MEDICAL HISTORY

Medical History

Patient First Name:	
Patient Last Name:	
Birth Date:	
Although dental personnel primarily treat the area in and around your mouth your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.	
Are you under a physician's care now?	◯ Yes ◯ No
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No
Have you ever had a serious head or neck injury?	◯ Yes ◯ No
Are you taking any medications pills or drugs?	◯ Yes ◯ No
Do you take or have you taken Phen-Fen or Redux?	◯ Yes ◯ No
Have you ever taken Fosamax Boniva Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No
Are you on a special diet?	◯ Yes ◯ No
Do you use tobacco?	◯ Yes ◯ No
Please answer each of the following questions concerning your sleep habits	
Are you experiencing memory loss?	◯ Yes ◯ No
Do you have a CPAP?	◯ Yes ◯ No
Do you have crowding of teeth?	◯ Yes ◯ No
Do you have difficulty sleeping or restl	◯ Yes ◯ No
Do you have night-time choking spells?	◯ Yes ◯ No
Do you have pauses in your breathing dur	◯ Yes ◯ No
Do you have persistent nasal congestion	◯ Yes ◯ No
Do you have problems opening your mouth?	◯ Yes ◯ No

Do you snore?	◯ Yes ◯ No
Do you suffer with daytime sleepiness?	◯ Yes ◯ No
Do you toss & turn while sleeping?	◯ Yes ◯ No
Do you wake up repeatedly?	◯ Yes ◯ No
Do you wake up with dry mouth?	◯ Yes ◯ No
Do you wake up with morning headaches?	◯ Yes ◯ No
Do you wear your CPAP?	◯ Yes ◯ No
Does your jaw lock or make noises?	◯ Yes ◯ No
Have you ever been diagnosed with sleep disorder?	◯ Yes ◯ No

Do you have concerns in any of these areas?

Ability to chew	◯ Yes ◯ No
Appearance	◯ Yes ◯ No
Bite	◯ Yes ◯ No
NONE	◯ Yes ◯ No
Smile	◯ Yes ◯ No
Snoring	◯ Yes ◯ No

Do any of the above complaints affect your daily life?	◯ Yes ◯ No
What results do you hope to achieve from sleep treatment?	◯ Yes ◯ No
Women: Are you...	☐ Nursing? ☐ Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives?
Are you allergic to any of the following?	☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Metal ☐ Penicillin ☐ Sulfa Drugs
Do you use controlled substances?	◯ Yes ◯ No
Other?	☐ Yes

Do you have or have you had any of the following?

AIDS/HIV Positive	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No
Angina	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No
Asthma	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No

Blood Transfusion	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No
Cancer	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No
Cortisone Medicine	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No
Dizziness	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No
Ear Pain/Ear Congestion	◯ Yes ◯ No
Easily Winded	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No
Excessive Thirst	◯ Yes ◯ No
Facial Pain	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No
Fatigue	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No
Frequent Diarrhea	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No
Genital Herpes	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No
Hay Fever	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No
Heart Pacemaker	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No
Hemophilia	◯ Yes ◯ No
Hepatitis A	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No
Herpes	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No

Hives or Rash	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No
Jaw Pain	◯ Yes ◯ No
Kicking or Jerking Legs	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No
Morning Hoarseness	◯ Yes ◯ No
Muscle Twitching	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No
Pain When Chewing	◯ Yes ◯ No
Parathyroid Disease	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No
Radiation Treatments	◯ Yes ◯ No
Recent Weight Loss	◯ Yes ◯ No
Renal Dialysis	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No
Rheumatism	◯ Yes ◯ No
Ringing in Ears	◯ Yes ◯ No
Scarlet Fever	◯ Yes ◯ No
Shingles	◯ Yes ◯ No
Sickle Cell Disease	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No
Spina Bifida	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No
Swelling of Limbs	◯ Yes ◯ No
Teeth Grinding	◯ Yes ◯ No
Throat or Neck Pain	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No
Tonsillitis	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No
Ulcers	◯ Yes ◯ No

Venereal Disease	◯ Yes ◯ No
Vision Problems	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No
Have you ever had any serious illness not listed above?	◯ Yes ◯ No
To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.	
Signature of Patient, Parent, or Guardian:	

Office Policies Consent Form

OFFICE POLICY

First Name	
Last Name	

DENTAL INSURANCE

Welcome to Dentistry at Park Place. We feel very honored that you are here. We believe in the importance of quality dental care and strive to provide the best dental treatment available. We work with most insurance companies as a courtesy and always try to maximize your benefits. We will file all insurance claims for you and will try to help you with any questions you may have regarding your insurance.

Please be aware that you are responsible for your estimated portion of your treatment that is not estimated to be covered by insurance on the day services are rendered. We allow 45 days for the insurance companies to pay our office. If they have not paid within 45 days, it is your responsibility to clear the balance remaining on the account. Please be assured we work very hard with the insurance companies to receive those payments. Please pay your balance promptly to avoid any collection costs.

WHILE WE STRIVE TO FAMILIARIZE OURSELVES WITH MOST MAJOR DENTAL BENEFIT PLANS, WE CAN MAKE NO GUARANTEES WHERE YOUR DENTAL BENEFITS ARE CONCERNED. YOUR BENEFITS ARE UNIQUELY YOURS AND WE WILL HELP YOU MAXIMIZE THE BENEFITS, YET IT 1S YOUR RESPONSIBILITY TO UNDERSTAND THE BENEFITS AND LIMITATIONS OF YOUR COVERAGE.

AGREEMENT TO PAY:

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees and/or court costs if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.

APPOINTMENTS

Our team is dedicated to staying on schedule and seeing all our patients on time for their appointments. We ask that our patients be on time for their appointment. Always allow time for traffic and any paperwork you might need to complete when you get here. Please be aware that dental emergencies do arise throughout the day which could delay or extend your appointed time. We are committed to treating all true emergencies and will advise you immediately as to the status of your appointment.

We require a verbal confirmation no less than 24 hours prior to your appointment time. If we are unable to reach you, your appointment may be cancelled. We make every effort to contact our patients with phone calls, emails and text messages.

A 24 hour business day notice is required if appointment change is needed. There is a $100 charge for canceling without proper notice. Please be aware this is subject to change.

PRE-PAYMENT FOR APPOINTMENTS

Any treatment plan that results in an estimated patient portion of $300 or more in a single visit, will require a 30% deposit to schedule and reserve the time. Also, procedures requiring more than one hour of reserved time will require a deposit. This deposit will be applied to the full co-payment amount due at the time of service. The deposit is NOT REFUNDABLE. In the event

the appointment is rescheduled, the deposit will remain on the dental account until applied to the treatment. A $25.00 deposit is required to reserve a new patient appointment. This deposit will be applied to the full co-payment amount due at the time of service. PLEASE NOTE THAT APPOINTMENTS RESCHEDULED WITH LESS THAN A 24 HOUR NOTICE MAY BE SUBJECT TO OUR $100 CANCELLATION FEE.

LATE POLICY

If you do not arrive at your scheduled appointment time, there is the possibility that a portion of your treatment may have to be rescheduled to a later date. When you are late you put us in a difficult position with other patients who were also previously scheduled. We will do what we can to accommodate everyone.

INFORMATION CHANGES

It is your responsibility to inform us of any changes so that we may keep your records updated. These changes can include, but are not limited to new address or phone, changes in medications or health history, changes to dental insurance.

We will require periodic updates to your records, so please expect that from time to time.

I HAVE READ AND UNDERSTAND THE ABOVE OFFICE POLICY.

Signature of Patient or Guardian:	
Date:	

CONSENT TO CONTACT PATIENT BY CELL PHONE

I agree in order for Dentistry at Park Place to service my account or to collect monies I may owe, you and your agents may contact me by telephone using any telephone number associated with my account, including wireless telephone numbers which may incur charges to me. You may also contact me by sending text messages and emails using any contact information I have provided you. Methods of contact may include using pre-recorded or artificial voice messages and use of automated dialing devices as applicable.

	☐ I have read this disclosure and agree that you and your agents may contact me as described.
Signature of Responsible Party:	

Dentistry at Park Place

Patient Registration Form

PATIENT INFORMATION

First Name: | Middle Initial: | Last Name: | Date of Birth: | Sex: | Family Status:

Social Security#: | Driver's License#: | Email: | HOME ADDRESS: | Country:

City: | State: | Zip Code:

PHONE NUMBERS

Please check preferred contact#: | Best time to call: | Home Phone#: | Work Phone#: | Cell Phone#:

Whom should we contact in an emergency? | Phone#: | Relationship: | Whom are we allowed to speack to about your dental health? (Besides you, parent, guardian, Insurance): | Whom may we thank for referring you?

PREFERENCES:

RESPONSIBLE PARTY INFORMATION
(If Not The Patient)

Person responsible for the account: | Phone#: | Relationship to Patient: | SSN#: | Date of Birth:

Street Address (City, State & Zip Code):

DENTAL INSURANCE

(Please input the policy holder's information)

Is the insurance policy holder a patient at this office?
- ○ Yes
- ○ No

If Yes, what is the policy holder's relationship to the patient? | Policyholder's full name: | Date of Birth: | SSN#:

Phone#: | Address (City, State & Zip Code):

Policyholder's Employment Information (If different then above)

Employer's Name: | Phone#: | Address (City, State & Zip Code):

Insurance company information

Insurance company Name: | Phone#: | Address (City, State & Zip Code): | Insurance Plan Name: | Insurance ID #:

Group ID#: | Union or Local Name:

SECONDARY INSURANCE
(If Applicable)

Is the secondary insurance policy holder a patient at this office?

- ○ Yes
- ○ No

If Yes, what is the secondary policy holder's relationship to the patient?

Secondary Policyholder's Full Name:

Date of Birth:

SSN#:

Address (City, State & Zip Code):

Secondary Policyholder's Employment Information

Employer's Name:

Phone#:

Employer's Address:

Secondary Insurance Company Information

Insurance Company Name:

Phone#:

Insurance Company Address (City, State & Zip Code):

Insurance Plan Name:

Insurance ID #:

Group ID#:

Union or Local Name:

HIPAA Form

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

● Treatment, payment and health care operations.

● Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include treatment for pain or injury to your teeth.

● Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

● Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identifiable health information by removing all references to individually Identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may also use or disclose your personally-identifiable health information:

● To your family and friends: We must disclose your information to you. We may also disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so, or if we are presented a valid legal document showing authority of another person to act on your behalf, as, for example, a medical power of attorney or declaration of guardianship.

● To persons involved in your care: We may use or disclose health information to notify, assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your general condition. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to use uses or disclosure.

● As required by law: we may use or disclose your health information when we are required to do so by law.

● In case of suspected 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.

● For other governmental purposes: we may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to correctional institution or law enforcement official having custody of protected health information of inmate or patient under certain circumstances.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

● The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

● The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

● The right to inspect and copy your protected health information.

● The right to amend your protected health information.

● The right to receive an account of disclosures of protected health information.

● The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.

● The right to request a written acknowledgment that you have received a copy of our Notice of Privacy Practices, and an obligation to document our good faith efforts why an acknowledgment was not obtained.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 OR the date office opened if later than April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you
may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse If you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil rights, about violation of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services

Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201
202.619.0257

You May Refuse To Sign This Acknowledgement

I, have received a copy of this office's notice of privacy practices	
Patient First Name:	
Patient Last Name:	
Signature:	
Date:	