PATIENT INFORMATION (Confidential and Necessary) Today's Date ___-___-___

Name_____ Birth Date: ___-___-___ Age:_____

Home Address_____City _____State_____ZIP_____

Phone Numbers: Home____-____-_____Work____-____-_____Cell ____-____-_____

e-Mail Address_____@_____Social Security Number _____-___-_____

Your Employer _____Position_____How Long?_____

Employer's Address_____City _____State____ZIP_____

Spouse/Parent/Guardian (circle one)_____Other Guardian_____

Their Employer_____Position_____How Long?_____

Nearest Relative Not Living With You_____Relationship?_____

Their Phone Number____-____-_____City _____State_____

Whom Should We Contact In An Emergency?_____Phone____-____-_____

Physician _____Phone Number____-____-_____

Person Responsible For This Account _____(signature)

_____

DENTAL INSURANCE INFORMATION (to process your claim)

Primary Dental Ins. Co. _____Employer_____Group#_____

Phone____-____-_____Annual Benefit Maximum_____Annual Deductible_____

Employee's Name_____SS#____-____-_____Birthdate____-____-____

Secondary Insurance Co._____Employer_____Group#_____

Phone____-____-_____Annual Benefit Maximum_____Annual Deductible_____

Employee's Name_____SS#____-____-_____Birthdate____-____-____

Whom May We Thank For This Referral (How did you find out about us)?_____

Are You Having Any Dental Problems? Yes No (please circle) Please Describe:_____

_____

Do You Having Any Hobbies or Special Interests?_____

_____

(Over)

PERSONAL NOTES AND INFORMATION

Other Family Members:

Is there anything that you would like us to know about you, your dental history, or any other concerns?

Do you have a fear of dental treatment that has prevented you from seeking the care that you need or want?
Yes No

Would you be interested in sedation, either Nitrous Oxide (laughing gas) or taking a medication to make your treatment proceed easier?
Yes No

Notes:

Informed Consent
General Consent for Treatment

I understand that I have the following conditions requiring dental treatment in the opinion of my dentist:

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side affects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that might require additional treatment
- Delayed healing of an extraction site, (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment of surgical repair at a later date
- Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, or pain
- Failure of the dental procedure necessitating additional treatment
- Breakage of dental instruments inside tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fee(s) involved have also been explained. All of my questions have been answered, and I have not been offered any guarantees.

Patient Signature_____ Date_____
Witness_____ Date_____

Craig C. Callen D.D.S. & Associates

PATIENT MEDICAL HISTORY

Date: / / Blood Pressure: /
(taken by our office)

MEDICAL ALERTS!

Patient Name: Age: Weight: Height:

1.) Have you been hospitalized in the last 5 years? Why?	YES	NO
2.) Are you taking any medications? What?	YES	NO
3.) Are you allergic to any medications? What?	YES	NO
4.) Do you use alcohol? How much a week?	YES	NO
5.) Do you use tobacco products? How much a day?	YES	NO
6.) Have you had any allergies or problems with Novocaine?	YES	NO
7.) Have you had any allergies to latex?	YES	NO
8.) Do you have any problem bleeding a long time if you cut yourself?	YES	NO
9.) WOMEN: Are you pregnant, or think you may be? What month?	YES	NO
Are you taking birth control pills?	YES	NO

10.) IF YOU HAVE HAD ANY OF THE FOLLOWING PROBLEMS, PLEASE CIRCLE THE CORRECT RESPONSE. IF SOMEONE IN YOUR FAMILY HAS HAD THE PROBLEM, PLEASE WRITE AN "F" FOR FAMILY NEXT TO THE CORRECT RESPONSE. THANK YOU.

Heart Disease or Attack	Jaundice or Liver Disease	Diabetes
Angina (Chest Pain)	Hepatitis A	Tuberculosis
Heart Murmur	Hepatitis B	Arthritis
Mitral Valve Prolapse	Hepatitis Non A, B	Rheumatism
Artificial Valve	A.I.D.S. or H.I.V.	Artificial Joints (or pins)
Pacemaker	Blood Transfusion	Cancer
High Blood Pressure	Hemophilia	Radiation Therapy
Low Blood Pressure	Venereal Disease	Chemotherapy
Swollen Ankles	Sinus Problems	Drug or Alcohol Problems
Anemia	Asthma	Psychiatric Treatment
Thyroid Disease	Hay Fever/ Allergies	Fainting or Dizziness
Glaucoma	Ulcers	Epilepsy

NOTES:

11.) Do you get shortness of breath, or chest pain walking up stairs?	YES	NO
12.) Do you need to prop yourself up with pillows to sleep?	YES	NO
13.) Do you have any health problems not listed? What?	YES	NO

To the best of my knowledge, all of the preceding answers are true and correct. I will inform the doctor if there are any changes in my health, or medicines at my next appointment. I am also now aware that the doctor may take pictures for diagnosis and documentation purposes and that I give my permission for these pictures to be used for educational and scientific purposes. I authorize the insurance company to pay the dentist benefits payable to me for services rendered and authorize the use of this signature for insurance submission. I authorize release of information to the insurance company. I understand that I am financially responsible for my treatment regardless of what my insurance may or may not pay.

Patient(Parent) Signature: Dr.

Craig C. Callen D.D.S. & Associates

MEDICAL HISTORY UPDATE PATIENT:

Date: / / Change in Health:

Change in Medications:

Patient Signature: Dr.

Date: / / Change in Health:

Change in Medications:

Patient Signature: Dr.

Date: / / Change in Health:

Change in Medications:

Patient Signature: Dr.

Date: / / Change in Health:

Change in Medications:

Patient Signature: Dr.

Date: / / Change in Health:

Change in Medications:

Patient Signature: Dr.

Date: / / Change in Health:

Change in Medications:

Patient Signature: Dr.

DENTAL HISTORY: Craig C. Callen D.D.S. & Associates

Patient name: | I.D. # | Date / /

1. What is your primary concern?_____
2. Is there anything you dislike about the looks of your teeth?_____
3. When was your last dental exam?_____Cleaning?_____
4. Have you been under regular care? Yes _____No_____
5. Why did you decide to change dentists?_____
6. Have you had any: Root canal? Yes_____No _____Gum treatment? Yes _____No_____
   Braces? Yes___No___Extractions? Yes No When?_____
   Why? _____Notes:_____
7. Do you have any replacements? Yes _____No_____When?_____
8. Do you snack between meals? Yes_____No _____Notes:_____
   Pop, Kool-aid, Coffee/Tea? _____How much?_____
9. How do you take care of your teeth on a daily basis?_____
   a.) Brushing: _____hard medium soft _____
   b.) Flossing: Yes_____No_____How often?_____
   c.) Mouthwash: Yes_____ No_____Brand?_____
   d.) Other:_____
   e.) Has a dentist or hygienist shown you how to brush and floss?
   Yes_____No_____
10. Do you ever notice your gums bleeding or tender when you brush or floss? Yes _____No_____ Where?_____
    How long?_____
11. Do you have any problem with bad breath? Yes_____No_____Notes:_____
12. Do you have any problem with food packing between your teeth?
    Yes_____ No_____Where?_____
13. Are you aware of any loose teeth? Yes_____No____ Where?_____
    _____How long?_____
14. Do you ever clench or grind your teeth? Yes_____ No____ When?_____
15. Do you ever notice your jaw popping or clicking? Yes _____No_____
    How long?_____ Any pain or limited opening?_____
16. Do you have any problems with frequent headaches? Yes_____ No_____
    When?_____
    Where?_____
    How many a week?_____
17. Have you ever worn a bite plane, night guard, or had your bite adjusted? Yes_____ No ___When?_____
18. Are there any other problems you feel we should be aware of?_____

19. PEDO: A.) Any injuries to face or teeth? _____
    B.) Are you or have you taken a fluoride vitamin or rinse? _____
    C.) Any habits? _____

TREATMENT EXPLANATION PATIENT: DATE: / /

TOOTH		EXISTING					SEALANT
	1						
	2						
	3						
A	4						
B	5						
C	6						
D	7						
E	8						
F	9						
G	10						
H	11						
I	12						
J	13						
	14						
	15						
	16						
	17						
	18						
	19						
K	20						
L	21						
M	22						
N	23						
O	24						
P	25						
Q	26						
R	27						
S	28						
T	29						
	30						
	31						
	32						
TOTALS							

SPECIALIST REFERRAL: _____

Craig C. Callen, D.D.S. & Associates L.L.C.

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements offcially began on April 14, 2003, While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPAA policy. The full policy is available for your review if you would like.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal exchange of information within our office. HIPAA provides certain rights and protections to you as the patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is avaliable from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov

This summarizes our policy here at Craig C. Callen, D.D.S. & Associates.

Patient information will be kept confidential except when it is necessary to provide services or to ensure that all administrative matters related to your care are handled properly. This may include, but not limited to, the sharing of information with other healthcare providers, laboratories, and health insurance companies. Patient information (treatment plans, insurance forms, eob's etc.) may be stored in file cabinets not accessible by patients. Preparing for and during your dental visit such records may be left, at least temporarily, in administrative areas such as the front office, doctors desk, examination room,etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

We send out reminders to our patients. We do this by one or more of the following; e-mail, texting, calling, and sending postcards. We try to make every effort to remind you of your appointment and any treatment that you need. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. We also may send out newsletters or special promotions that we are offfering.

You agree to us sending electronic e-referrals to specialists, which include your PHI and x-rays, if needed. We also send electronic claims to your dental insurance, which includes submitting PHI to receive payment for services provided.

You give us permission to remind you to take pre-medication prior to appointmants, if applicable.

You give us permission to call in any prescriptions you may need and share your PHI with the pharmacist.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor, and understand that you have the right to file a complaint. We can help you do this, and you will not be penalized for filing a complaint.

Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services without your permission.

We agree to provide patients with access to their records in accordance with state and federal laws. We may update this policy as needed to better serve the needs of our patients and our practice.

By signing below, I agree that, I have been offered the HIPAA policy, and understand and acknowledge my agreement to the terms set forth in the HIPAA information and consent form and any future update to this policy.

Patient: _____

Signature: _____

Date: _____

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Craig C. Callen & Assoc. L.L.C. to disclose your PHI to the following individuals (check all that apply).

Name: ______________________________ **Relationship to Patient:** ________________
Telephone: (______)________________ **Email:**________________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

Name: ______________________________ **Relationship to Patient:** ________________
Telephone: (______)________________ **Email:**________________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

Name: ______________________________ **Relationship to Patient:** ________________
Telephone: (______)________________ **Email:**________________________________
Types of Information: ☐ Appointment Reminders ☐ Results (X-Ray, etc) ☐ Financial ☐ Other: __________
Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Patient Portal & Secure Email ☐ Other: __________

☐ **None of the above** **Signature:** ______________________________

VA Acknowledgment

Last Name: First Name: Birthdate:

Date: 05/21/2024

VA PATIENTS ONLY:

We are a privately owned and run Community Care Provider for the VA dental program. We reserve time in our schedule to provide quality care to you. We are required to notify the VA of any appointments, any time you change an appointment, or any missed appointments. After two (2) unexcused appointments the VA will require you to return to their facility for any further treatment. To avoid the unnecessary hardship on you and lost time for us. If you are unable to make your appointment we ask that you give us at least two (2) business days notice. Thank you for your understanding.

Drs. Craig Callen DDS & Associates

X_____

Craig C. Callen, D.D.S. & Associates

Dr. Craig Callen
552 South Trimble Road • Mansfield, OH 44906
(419) 756.0188

SLEEP HEALTH QUESTIONAIRE

Patient Name: _____

Chief Sleep Complaint

__ Snoring __ Stop breathing during sleep __ Sleep apnea __ Sleepiness

__ Fatigue __ Insomnia __ Other _____

Severity: (circle one) mild / moderate / severe **Duration:** (circle one) weeks / months / years

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? Use the following scale to tell us how likely you are to doze: **0 - no chance 1 - slight chance 2 - moderate chance 3 - high chance**

Sitting and reading	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Watching television	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting inactive in a public place (such as theatre or a meeting)	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
s a passenger in a car for an hour without a break	0	1	2	3
n a car, while stopped for a few minutes in traffic	0	1	2	3

Berlin Questionnaire

Do you snore?
__ Yes
__ No
__ Don't know

Snoring loudness
__ Loud as breathing
__ Loud as talking
__ Louder than talking
__ Very loud

Snoring Frequency
__ Almost every day
__ 3 to 4 times per week
__ 1 to 2 times per week
__ 1 to 2 times per month
__ Never or almost never

Does your snoring bother other people?
__ Yes
__ No

ow often have you or your spouse noticed pauses in your breathing?
__ Almost every day
__ 3 to 4 times per week
__ 1 to 2 times per week
__ 1 to 2 times per month
__ Never or almost never

Are you tired after sleeping?
__ Almost every day
__ 3 to 4 times per week
__ 1 to 2 times per week
__ 1 to 2 times per month
__ Never or almost never

Are you tired during wake time?
__ Almost every day
__ 3 to 4 times per week
__ 1 to 2 times per week
__ 1 to 2 times per week
__ 1 to 2 times per month
__ Never or almost never

Have you ever fallen asleep while driving?
__ Yes
__ No

Do you have high blood pressure?
__ Yes
__ No

Patient Name: _____

SLEEP HEALTH QUESTIONAIRE - Continued

Sleep Habits

How much time do you spend in bed trying to sleep during a 24-hour period? __ Less than 5 hrs __ 5-7 hrs __ 7-8 hrs __ 8+ hrs

How much of that time do you actually sleep? __ Less than 5 hrs __ 5-7 hrs __ 7-8 hrs __ 8+ hrs

What is your normal bedtime? _____ What is your normal wake-up time? _____

Do you rotate shifts in your job(s)? __ Yes __ No

Sleep Behavior

Do you have difficulty falling asleep? __ Yes __ No

How many times each night do you wake up? __ 0 __ 1-2 times __ 3+ times

Does pain interfere with your sleep? __ Yes __ No

Do you dream? __ Yes __ No

Do you have trouble breathing through your nose at night? __ Yes __ No

Other Sleep Behavior

How often does an uncomfortable urge to move your legs, ("restless legs") make it difficult to fall asleep?

__ Never __ Rarely __ Sometimes __ Frequently __ Most of the time

If so, does movement temporarily remove the discomfort? __ Yes __ No

I have been told I kick or twitch my legs when asleep.

__ Never __ Rarely __ Sometimes __ Frequently __ Most of the time

I have been told I grind or clench my teeth when sleeping.

__ Never __ Rarely __ Sometimes __ Frequently __ Most of the time

Do you wake up in the morning with a headache?

__ Never __ Rarely __ Sometimes __ Frequently __ Most of the time

Cataplexy

Has strong emotion (surprise, laughter, anger, etc.) ever provoked localized weakness or even a fall?

__ Never __ Rarely __ Occasionally

Sleep Apnea Test & Treatment

Have you ever had a sleep study? __ Yes __ No Results _____

If so, when _____ Where _____

Have you ever been treated with: __ CPAP __ Oral Appliance __ Nasal Surgery __ Throat Surgery

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AFFIDAVIT FOR INTOLERANCE TO CPAP

Patient Name: _____

I have attempted to use CPAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reason(s):

_____ Does Not Seem to Be Effective

_____ Mask Uncomfortable/Device Uncomfortable

_____ Unable to Sleep Comfortably/Fall Asleep Easily

_____ Noise Disrupts Me And/Or My Spouse/Bed Partner's Sleep

_____ Straps/Headgear Cause Discomfort

_____ Intolerable Mouth or Mask Leaks

_____ Pressure on the Upper Lip Causes Tooth Related Problems

_____ Tethering Disrupts Movement During Sleep

_____ Latex Allergy

_____ Claustrophobia

_____ Other _____

Date CPAP Therapy Ended: _____ Name of CPAP Provider: _____

Was it paid for by insurance? __ Yes __ No Name of Insurance Provider: _____

Because of my intolerance/inability to use CPAP Therapy, I wish to have an alternative method of treatment. That form of therapy is an Oral Airway Dilator Appliance, as recommended by my Sleep Study's interpreting physician and prescribed to me by my Dentist.

Signed: _____ Date:_____

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Dr. Craig Callen
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PERMISSION TO USE MEDICAL INFORMATION

It is our goal to always provide you with the highest standards of care. To that end, we are constantly trying to improve the results of our patients who proceed with therapy. Our ability to anonymously use some of the data we collect about you during diagnosis and treatment can be extremely helpful.

Tracking the results of your treatment and comparing it to the treatment of other patients allows us to track outcomes and ultimately provide better service to you and other patients.

We are asking your permission to use the some of the medical information we collect about you for:
- National Studies that look to improve Medical Outcomes for sleep disorders
- Compare your results to the results of other patients so that we can continue to refine our best practices

We greatly appreciate your cooperation. Any of your medical information is used in the strictest confidentiality. Information used for studies is anonymous and used only for statistical analysis.

Your signature below authorizes us to use your medical information for future studies.

Information regarding my diagnosis and therapy related to snoring and other potential sleep disorders can be used anonymously for future studies and outcome analysis.

_____
Print Name

_____ _____
Signature Date

INFORMED CONSENT DOCUMENT (DDS should tweak to their practice)

You may have been diagnosed by your physician as required treatment for sleep-disordered breathing (snoring and/or obstructive sleep apnea). This condition may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels which in turn may result in the following: Excessive daytime sleepiness, irregular heartbeat, high blood pressure, heart attack or stroke.

What is Oral Appliance Therapy?

Oral appliance therapy for snoring/Obstructive sleep apnea attempts to improve breathing during sleep by keeping the tongue and jaw in a slightly forward position during sleeping hours. Oral appliance therapy has effectively treated many patients. However, there are no guarantees that it will be effective for you since everyone is different and there are many factors influencing the upper airways during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance will give you maximum relief of symptoms. An overnight sleep study will likely be necessary to confirm the effectiveness of treatment. This must be obtained from your physician.

Side Effects and Complications of Oral Appliance Therapy

Published studies show that short-term side effects of oral appliance use may include excessive salivation, difficulty swallowing (with appliance in place), sore jaws, sore teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth and short-term changes in bite. There are also reports of dislodgment of ill fitting dental restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance. Long-term complications include changes in the bite that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, restorative dental treatment or orthodontic intervention may be required for which you will be responsible.

Follow-up visits in our office are mandatory to insure proper fit and allow an examination of your mouth and jaw to assure a healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended you cease using the appliance until you are evaluated further.

Alternative Treatment for Sleep-Disordered Breathing

Other accepted treatments for sleep-disordered breathing include behavioral modification, positive airway pressure (CPAP), and various surgeries. It is your decision to have chosen oral appliance therapy to treat your sleep-disordered breathing, and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address to the doctor. Failure to treat sleep-disordered breathing may increase the likelihood of significant medical conditions .

If you understand the ecplanation of the proposed treatment and have asked the doctor and wuestions you may have about this form of treatment, please sign and date the form below. You will receive a copy.

Signed _____ Date _____