Dental Anxiety Scale for _____

1. If you had to go to the dentist tomorrow, how would you feel about it?

a) I would look forward to it as a reasonably enjoyable experience.
b) I wouldn't care one way or the other.
c) I would be a little uneasy about it.
d) I would be frightened of what the dentist might do.

2. When you are waiting in the dentist's office for your turn in the chair, how do you feel?

a) Relaxed
b) A little uneasy
c) Tense
d) Anxious
e) So anxious that I sometimes break out in a sweat or almost feel physically sick.

3. When you are in the dentist's chair waiting while he gets the drill ready to begin working on your teeth, how do you feel?

a) Relaxed
b) A little uneasy
c) Tense
d) Anxious
e) So anxious that I sometimes break out in a sweat or almost feel physically sick.

4. You are in the dentist's chair to have your teeth cleaned. While you are waiting and the dentist is getting out the instruments to scrape your teeth around the gums, how do you feel?

a) Relaxed
b) A little uneasy
c) Tense
d) Anxious
e) So anxious that I sometimes break out in a sweat or almost feel physically sick.

General Consent for Dental Treatment

Endless Smiles Dental Group - Frederick C. Lally, D.D.S., M.A.G.D.

I understand the purpose of this general consent is to raise my awareness of the risks that are common-place in many dental procedures.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for a patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. One alternative for me is to do nothing, which carries its own risks.

My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur with regularity. For routine fillings, dental cleanings, prescription of medications, I understand this includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed. Medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, medications prescribed or used in the dental office could have an adverse interaction, and I need to fully disclose all of my medications to the dentist and pharmacist. This includes over the counter medications and herbal supplements.

I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases patients have had an allergic reaction to the anesthetic, or temporary or permanent injury to nerve and/or blood vessels from the injection. I understand the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I have the right to ask the doctor or hygienist for more information if I have any concerns about my procedures and the possible side effects or complications. I promise to use that right to its fullest intent if for any reason I feel I am not fully informed about my procedure, the risk of the procedures, and my alternative to the procedure.

_____

Signature

_____

Name of Patient

Endless Smiles Dental Group
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.

Name of responsible party:

_____
(Signature of patient, parent or guardian, if minor.)

Date_____

Please list persons with whom we may share your protected health information below:

_____
(First Name) (Last Name) (Relationship)

_____
(First Name) (Last Name) (Relationship)

_____
(First Name) (Last Name) (Relationship)

Revocation of rights to your protected health information must be made in writing and will be effective from the date of written submission.

_____

FOR OFFICE USE ONLY

_____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment 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.)

_____

Endless Smiles Dental Group

Frederick C. Lally, DDS

Office Financial Policy

Payment is due at the time services are rendered. For your convenience we accept cash, Visa, Master Card, Discover, local personal checks, money order, or registered check.

Insurance benefits are determined by your employer and not by your dentist. Insurance is not a guarantee of payment; insurance companies will not pay for all your costs. Your insurance policy is a contract between you and your insurer. Your insurance and payment are still your responsibility. As a courtesy we will be glad to file your claim for you if you bring your dental insurance card and all required employer information. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment. **If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible from you.**

We reserve the right to charge and collect for broken appointments - appointments that are cancelled or broken with less than 48 hours advanced notice or no notice at all. Appointments are reserved exclusively for you. As a health benefit for you, we may offer to move your appointment to an earlier time if openings arise.

In the event of a returned check, a fee of $50 will be added to your account balance.

Payment plans and financial arrangements can be entered into for comprehensive dental treatment, prior to commencing treatment.

I have read and understand this financial policy.

_____

Patient Signature

Time 12:50 PM | Endless Smiles Dental Group, LLC | Date 1/12/2016

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

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	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed	○ Yes ○ No	If yes

Comments:

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:

X Date:_____