Patient Information

Date ____________________

Patient Information

Name ____ Preferred Name ____________________ Sex: M F
Title Last First MI (Circle one)
Address ____
Street City State Zip
Married Single Child Other Phone: Home ( ) - Work ( ) - Cell ( )
(Circle one)

Date of Birth ____________ Social Security # ____________ Email: ____________________

If employed, place of employment (name, address, phone) ________________________________
If full time student, school ____________________

Whom should we contact in case of an emergency?
Name ____________________ Relationship ____________________ Phone ____________________

Head of Household/Billing Information **If same as above, check here __**

Name ____ Nickname ____________________
Title Last First MI
Address ____
Street City State Zip
Date of Birth ____________________ Phone: Home ( ) - Work ( ) - Ext. ________

Social Security # ____________________ Place of Employment ____________________

Primary Dental Insurance Information

A. Information about person carrying the insurance
Name ____ Date of Birth ____________________

Home Address ______________________________________ Home Phone ____________________

SS# ____________________ **Relationship of the PATIENT TO this person: Self Child Spouse Other
(Circle one)

B. Employer Name ______________________________ Group/Plan # ____________________
Address ______________________________ Phone ____________________

C. Insurance Company Name ______________________________ ID#: ____________________
Address ____

Do you have Secondary Insurance? ____________

Cancelled and missed appointments cost the practice time and valuable resources which could be used to benefit other patients waiting for an appointment. For this reason, we may require you to make a non-refundable deposit / prepayment for extensive procedures. This office does require a 24-hour notice for any cancelled and/or rescheduled appointments. We reserve the right to charge a minimum of $50 if you do not provide 24-hour notice. However, dependent upon the length of your appointment, the charged amount could be greater than $50. By signing below, you acknowledge that you understand this policy.

SIGNATURE ______________________________________ DATE ____________________

MEDICAL HISTORY

Patient Name________________________ DOB________________
Name of Primary Care Physician________________________________
Most recent physical examination________________________ Purpose________________
What is your estimate of your general health? □ Excellent □ Good □ Fair □ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury ____________	□	□
2. an allergic reaction to		
□ aspirin,ibuprofen,acetaminophen,codeine		
□ penicillin		
□ erythromycin		
□ tetracycline		
□ sulpha		
□ local anesthetic		
□ fluoride		
□ metals (nickel,gold,silver,__________)		
□ latex		
□ other		
3. heart problems, or cardiac stent within the last six months	□	□
4. history of infective endocarditis ____________	□	□
5. artificial heart valve, repaired heart defect (PFO)________	□	□
6. pacemaker o implantable defibrillator ____________	□	□
7. artificial prosthesis (heart valve or joints) ____________	□	□
8. rheumatic or scarlet fever ____________	□	□
9. high or low blood pressure____________	□	□
10. a stroke (taking blood thinners) ____________	□	□
11. anemia or other blood disorder ____________	□	□
12. prolonged bleeding due to a slight cut (INR>3.5)________	□	□
13. emphysema, sarcoidosis ____________	□	□
14. tuberculosis ____________	□	□
15. asthma____________	□	□
16. breather or sleep problems (i.e. snoring, sinus)________	□	□
17. kidney disease____________	□	□
18. liver disease____________	□	□
19. jaundice ____________	□	□
20. thyroid, parathyroid disease, or calcium deficiency ______	□	□
21. hormone deficiency ____________	□	□
22. high cholesterol or taking statin drugs ____________	□	□
23. diabetes (HbA1c=___)____________	□	□
24. stomach or duodenal ulcer____________	□	□
25. digestive disorders (i.e. gastric reflux) ____________	□	□

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	□	□
27. arthritis ____________	□	□
28. glaucoma____________	□	□
29. contact lenses ____________	□	□
30. head or neck injuries____________	□	□
31. epilepsy, convulsions (seizures) ____________	□	□
32. neurologic problems (attention deficit disorder) ________	□	□
33. viral infections and cold sores ____________	□	□
34. any lumps or swelling in the mouth ____________	□	□
35. hives, skin rash, hay fever____________	□	□
36. venereal disease ____________	□	□
37. hepatitis (type ___) ____________	□	□
38. HIV/AIDS____________	□	□
39. tumor, abnormal growth ____________	□	□
40. radiation therapy ____________	□	□
41. chemotherapy ____________	□	□
42. emotional problems____________	□	□
43. psychiatric treatment____________	□	□
44. antidepressant medication ____________	□	□
45. alcohol/drug dependency ____________	□	□
ARE YOU:		
46. presently being treated for any other illness ____________	□	□
47. aware of a change in your general health ____________	□	□
48. taking medication for weight management (i.e. fen-phen) _	□	□
49. taking dietary supplements ____________	□	□
50. often exhausted or fatigued____________	□	□
51. subject to frequent headaches ____________	□	□
52. a smoker or smoked previously____________	□	□
53. considered a touchy person ____________	□	□
54. often unhappy or depressed ____________	□	□
55. FEMALE – taking birth control pills ____________	□	□
56. FEMALE - pregnant____________	□	□
57. MALE – prostate disorders ____________	□	□

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

____

List all medications, supplements, and/or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISOTRY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature________________________ Date________________

SLEEP SCREENING QUESTIONNAIRE

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations?

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**

Sitting and reading ________
Watching television ________
Sitting inactive in a public place ________
As a car passenger for a hour without a break ________
Lying down to rest in the afternoon ________
Sitting and talking to someone ________
Sitting quietly after lunch without alcohol ________
In a car, while stopping for a few minutes in traffic ________

TOTAL SCORE ________

THORNTON SNORING SCALE

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her, both physically and emotionally. Use the following scale to choose the most appropriate number for each situation. (Go to the 4th statement if you have no bed partner.)

0 = never **1 = infrequently (1 night per week)**

2 = frequently (2-3 nights per week) **3 = most of the time (4 or more nights per week)**

My snoring affects my relationship with my partner ________
My snoring requires us to sleep in separate rooms ________
My snoring is loud ________
My snoring affects people when I am sleeping away from home ________

TOTAL SCORE ________

Patient Name____ Date____________________

DENTAL HISTORY

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist________________________ How long have you been a patient? ________________ Months/Years
Date of most recent dental exam ______________ Date of most recent x-rays ________________
Date of most recent treatment (other than a cleaning) ________________
I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	Yes	No
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] ____________	☐	☐
2. Have you had an unfavorable dental experience?____________	☐	☐
3. Have you ever had complications from past dental treatment? ____________	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ____________	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ____________	☐	☐
6. Have you had any teeth removed? ____________	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change?____________	☐	☐
8. Have you ever whitened (bleached) your teeth? ____________	☐	☐
9. Have you felt uncomfortable or self-conscious about the appearance of your teeth? ____________	☐	☐
10. Have you been disappointed with the appearance of previous dental work?____________	☐	☐
BIT AND JAW JOINT		
11. Do you have problems with your jaw joint (pain,sounds,limited opening,locking,popping) ____________	☐	☐
12. Do you/would you have any problems chewing gum?____________	☐	☐
13. do you/would you have any problems chewing bagels,baguettes,protein bars, or other hard foods? ____________	☐	☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn?____________	☐	☐
15. Are your teeth crowding or developing spaces? ____________	☐	☐
16. Do you have more than one bite and squeeze to make your teeth fit together? ____________	☐	☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?____________	☐	☐
18. Do you clench your teeth in the daytime or make them sore? ____________	☐	☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? ____________	☐	☐
20. Do you wear or have you ever worn a bite appliance? ____________	☐	☐
TOOTH STRUCTURE		
21. Have you had any cavities within the past 3 years?____________	☐	☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ____________	☐	☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ____________	☐	☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ____________	☐	☐
25. Do you have grooves or notches on your teeth near the gum line?____________	☐	☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?____________	☐	☐
27. Do you get food caught between any teeth? ____________	☐	☐
GUM AND BONE		
28. Do your gums bleed when brushing or flossing? ____________	☐	☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ____________	☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? ____________	☐	☐
31. Is there anyone with a history of periodontal disease in your family? ____________	☐	☐
32. Have you ever experienced gum recession?____________	☐	☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _	☐	☐
34. Have you experienced a burning sensation in your mouth? ____________	☐	☐

Patient's Signature________________________________ Date________________

BENEFIT ASSIGNMENT AUTHORIZATION:

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim – past, present, and future. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to this practice as applicable. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

DATE SIGNATURE OF PATIENT/Parent if a minor

We appreciate knowing how you chose our practice. Please check all that apply.

Reputation for quality___ Yellow Pages___ Location___ Radio___Newspaper___Direct Mail___Other____________________

If you had a personal referral, whom may we thank?

Name____Address____

FINANCIAL POLICY

I have reviewed the information above and assert that it is accurate to the best of my knowledge. I understand that I am financially responsible for all charges rendered, whether or not paid by an insurance carrier, and balances over 60 days will be charged a monthly service fee for each month the balance is carried. In the case of default, I promise to pay any legal interest on balances due together with any collection costs and reasonable attorneys' fees incurred to effect collection of this account. I understand that, where appropriate, credit bureau reports may be obtained.

Signature of Patient (or guardian if patient is a minor) **Date**

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct Dr. John E. Clary and/or dental auxiliaries of his choice, to perform the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
   - A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
   - B. Application of plastic "sealants" to the grooves of the teeth.
   - C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
   - D. Replacement of missing teeth with dental prostheses. (bridges, partial dentures, full dentures)
   - E. Removal (extraction) of one or more teeth.
   - F. Treatment of diseased or injured oral tissues (hard and/or soft).
   - G. Use of sedative drugs to control apprehension and/or disruptive behavior.
   - H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
   - I. Use of general anesthesia to accomplish the necessary treatment.
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.
3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
7. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Signature: Patient or Parent/Guardian **Date**

Expressions Dental

515 Grand Ave., Suite 101, Ames, IA 50010

Notice of Privacy Practices Acknowledgement Form

Patient's Name: (First Name, Last Name):	Date of Birth:

I understand that as part of my dental care, Expressions Dental creates and maintains health records that describe my health history, dental information, symptoms, examinations, test results, diagnosis, procedures, treatment, and plans for future care or treatment I may receive. I understand that health information collected and stored will be used for the following:

- To support my care and treatment at Expressions Dental (treatment)
- For continued treatment among health professionals who are involved and contribute to my health care (treatment)
- For billing purposes including information regarding my diagnosis, treatment, and services rendered (payment)
- For insurance claim processing by a third-party payers for verification of services billed (payment)
- A tool for routine healthcare operations such as assessing quality improvement (healthcare operations)

I understand that the Notice of Privacy Practices from Expressions Dental defines more information regarding the use and disclose of my protected health information as well as my rights to my health information. By signing this, I acknowledge that Expressions Dental has offered me a copy of their Notice of Privacy Practices. I acknowledge and understand the rights that I have over my protected health information. I authorize the use and disclosure of my protected health information as specified in the Notice of Privacy Practices. I authorize the use and disclosures for treatment, payment, and healthcare operations purposes for Expressions Dental.
I authorized Expressions Dental to communicate regarding my dental treatments to the following individual(s):

____

____

I understand that I am ultimately responsible for all charges incurred for dentistry performed at Expressions Dental office including balances left after insurance payment has been received.

I understand that Expressions Dental communicates through text messaging about appointment reminders that contain patient specific information. I agree to the communication through text messaging unless I select the box below.

☐ I do not wish to receive text message communication for appointment reminders (Check to Opt Out)

This consent will continue forever unless I cancel it by writing to: Expressions Dental, 515 Grand Ave., Suite 101, Ames, IA 50010; if the consent is cancelled, it will not change releases that have already been made prior to the date of cancellation. I don't want the consent to never expire, please expire the consent as of: ____________________.
I understand that I can get an electronic copy of the Notice of Privacy Practices at www.expressions-dental.com.

________________________________ ____________________

Patient's Signature/Legal Representative Signature Date (MM/DD/YYYY)

If Legal Representative, relationship to Patient (parent, guardian, ect) ____________________________

Optional: Please e-mail me a copy of the Notice of Privacy Practices to the following e-mail address:

____

Internal Use:

If patient refuses to sign, please have 2 staff members of Expressions Dental Sign Below:

__________________________ __________________________

Staff's Signature Staff's Signature

Reason for Refusal of Signature: ______________________________________