PATIENT INFORMATION (CONFIDENTIAL)

DATE _____

NAME _____ PREFERRED NAME _____
First MI Last

ADDRESS _____ CITY _____ STATE_____ ZIP _____

EMAIL _____ HOME PHONE _____ CELL PHONE_____

SOC. SEC # _____ BIRTHDATE _____ SEX _____M OR _____F

EMPLOYER _____ WORK PHONE _____

SPOUSE OR PARENT'S NAME _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

INSURANCE INFORMATION

NAME OF SUBSCRIBER _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER DATE OF BIRTH _____ SUBSCRIBER SOC. SEC # _____

(FOLLOWING INFORMATION MAY BE PROVIDED ON THE INSURANCE CARD)

NAME OF INSURANCE COMPANY _____ TEL. # _____

POLICY ID #_____ GROUP # _____

EMPLOYER NAME _____

OFFICE POLICIES AND PROTOCOLS

24 hour notice request for any canceled and/or rescheduled appointments. Our office values our time with you as a patient, we always set sufficient amount of time needed to care for your needs. It is very difficult to fill time slots when appointments are not kept by patients and canceled or broken without 24 hour notice. We understand that emergencies may arise, however, if an emergency is not involved, please be courteous enough to respect our time as well as fellow patients. Initial _____

Short Call List- If a patient cancels or "no shows" for an appointment without giving us the requested 24 hours notice it is considered a BROKEN appointment. Once a patient has "broken" 2 appointments within a 6 month period, they will be placed on a Short Call list. This means that we are not able to make any future dental appointments for this patient. The patient may phone in on the same day that they are available and if our schedule permits, we will be happy to see you as a Same day patient. Initial _____

15 Minute Appointment Time Allowance- Our office prides itself on running a very organized schedule with minimal waiting time out of respect for your busy schedule. In consideration for our other patients who also have busy schedules we will only allow a patient to be 15 minutes late for a scheduled appointment. If you arrive more than 15 minutes late for an appointment, our office will have to cancel this appointment and reschedule it to a more suitable time. This is also considered a "broken" appointment and will apply to the above policy.

Initial _____

By signing below, I understand and agree to the policies listed above along with the information given to be correct. I understand that it is my responsibility to inform Fossil Creek Dental of any changes to the above information.

SIGNATURE OF PATIENT OR PARENT OF MINOR _____

PATIENT MEDICAL HISTORY

Patient Name_____**Date of Birth** _____

ALTHOUGH DENTAL PERSONEL 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 IMPORTAQNT IN-TERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
ARE YOU IN GOOD HEALTH.....	____	____
HAVE THERE BEEN ANY CHANGES IN	____	____
YOUR GENERAL HEALTH W/N THE PAST YEAR...	____	____
DATE OF YOUR LAST EXAM: _____		
PHYSICIAN'S NAME _____		
PHONE NO. _____		
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS	____	____
PLEASE EXPLAIN _____		
_____		
ARE YOU TAKING ANY MEDICATION(S)	____	____
INCLUDING NON-PRESCRIPTION MEDICINE....		
IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____		
_____		
HAVE YOU HAD ANY ABNORMAL BLEEDING.....	____	____
DO YOU BRUISE EASILY.....	____	____
DO YOU DRINK REGULARLY.....	____	____
HAVE YOU EVER TAKEN FOSAMAX, BONIVA,	____	____
ACTONEL OR ANY CANCER MEDICAITIONS	____	____
DO YOU USE TOBACCO?.....	____	____
DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES.....	____	____
DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT.....	____	____
HAVE YOU OR ANYONE IN YOUR IMMEDIATE FAMILY HAD OR BEEN DIAGNOSED WITH CANCER?	____	____

WOMEN ONLY

ARE YOU PREGNANT OR THINK YOU MAY BE PREGANT	____	____
ARE YOU NURSING.....	____	____
ARE YOU TAKING BIRTH CONTROL PILLS	____	____

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:

	YES	NO
LOCAL ANESTHTICS LIKE NOVOCAINE.....	____	____
PENICILLIN OR OTHER ANTIBIOTICS.....	____	____
SULFA DRUGS.....	____	____
BARBITURATES, SEDATIVES,.....	____	____
IODINE.....	____	____
ANY METALS (E.G., NICKEL, MERCURY, ETC).	____	____
LATEX/RUBBER.....	____	____
OTHER (PLEASE LIST)_____		

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

	YES	NO
RHEUMATIC HEART DISEASE	____	____
RHEUMATIC FEVER.....	____	____
HEART DEFECT OR HEART MURMUR.....	____	____
HEART ATTACK/TROUBLE OR ANGINA.....	____	____
CHEST PAIN.....	____	____
SHORTNESS OF BREATH.....	____	____
PACEMAKER.....	____	____
HEART SURGERY.....	____	____
HIGH/LOW BLOOD PRESSURE.....	____	____
CONGENITAL HEART PROBLEM.....	____	____
HEPATITIS, JAUNDICE, OR LIVER DISEASE		
STROKE.....	____	____
SINUS TROUBLE.....	____	____
LUNG OR BREATHING PROBLEMS.....	____	____
ASTHMA OR HAY FEVER.....	____	____
FAINTING OR DIZZY SPELLS.....	____	____
DIABETES.....	____	____
AIDS OR HIV INFECTION.....	____	____
THYROID PROBLEMS.....	____	____
ARTHRITIS OR RHEUMATISM.....	____	____
JOINT REPLACEMENT OR IMPLANT.....	____	____
STOMACH ULCER.....	____	____
KIDNEY TROUBLE.....	____	____
TUBERCULOSIS.....	____	____
PERSISTENT COUGH/BLOOD W/ COUGH...	____	____
CHEMOTHERAPY (CANCER, LEUKEMIA)....	____	____
SEXUALLY TRANSMITTED DISEASE.....	____	____
HPV (HUMAN PAPILLOMA VIRUS).....	____	____
WARTS.....	____	____
EPILEPSY OR SEIZURES.....	____	____
GLAUCOMA.....	____	____
TONSILLITIS.....	____	____
TUMORS.....	____	____
MENTAL HEALTH CARE.....	____	____
BACK PROBLEMS.....	____	____
CHEMICAL DEPENDENCY.....	____	____
MITRAL VALVE PROLAPSE.....	____	____
CORTISONE TREATMENT.....	____	____
COLD SORE/FEVER BLISTERS.....	____	____
HYPOGLYCEMIA.....	____	____
EATING DISORDERS.....	____	____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTANBD THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDINTG INCORRECT INFORMATION CAN BE DANGEROUD TO MY HEALTH. I AUTHRORIZE THE INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYA-BLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RE-SPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X_____ Date_____

Signature of Patient or Parent/Guardian if minor

PATIENT'S NAME _____Date_____

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

SITUATION	**BEFORE THERAPY**	
Sitting and reading	_____	_____
Watching Television	_____	_____
Sitting inactive in a public place (i.e. theater)	_____	_____
As a car passenger for an 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	_____	_____

**A score of 6 or greater indicates the possibility of sleep disordered breathing

SNORING

1. Do you snore no matter what position you are lying in?	Yes	No	Do Not Know
2 Do you snore every night?	Yes	No	Do Not Know
3. Is your snoring interrupted by pauses and/or choking sounds?	Yes	No	Do Not Know
4. Has your sleep mate ever commented on your snoring?	Yes	No	Do Not Know
5. Do you "grind" your teeth at night?	Yes	No	Do Not Know
6. Do you have high blood pressure?	Yes	No	Do Not Know

7. On a scale of 1-10 with 10 being loudest, how loud is your snoring? _____

Acknowledgement Of Receipt

Of

Notice Of Privacy Practices

I, _____ have been given the opportunity to review and receive a copy upon request of **FOSSIL CREEK DENTAL** Notice of Privacy Practices.

_____

(Signature Of Patient)

Staff Will Fill Out This Section If Patient's Signature is Not Obtained

Our Office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient Refused to sign.

____ Emergency situation kept us from obtaining the patient's signature.

____Language Barrier kept us from obtaining the patient's signature

____ Other _____