ORLAND DENTAL CARE
SMILE DENTAL CARE

Dear Patient,
If you do not have dental insurance your payment is due on or around the time of service. We will be happy to arrange a payment plan with you. Also, our office is happy to submit insurance claims for you. We will also be glad to go over an ESTIMATED cost of your dental services. It is important for you to know that we bill insurances companies as a courtesy and cannot be held responsible if they do not pay or receive claims in a reasonable amount of time. It is also important for you to know that we do estimate your portions on the information your insurance companies give us. It is not a guarantee that is what they will cover. We accept both managed care and standard insurance plans. Please keep in mind that most insurance companies do not cover 100% of dental procedures. We encourage you to discuss and understand your dental insurance along with your insurance company. Any questions regarding your treatment plan should be discussed with your dentist.

PLEASE READ AND SIGN BELOW SHOWING YOU UNDERSTAND THE FOLLOWING:

- I understand that my insurance policy may, or may not cover all dental services and that it is my responsibility to call my insurance company to verify mine as well as my family's coverage on dental procedures to be performed on myself or my family.
- My insurance plan may have a deductible and/or co-payment amount which is due at the time of service. I understand that I will be responsible for any other portions not covered by my insurance company.
- Any flex plan reimbursement will be paid directly to me upon submission of my paid receipts to my company.
- I accept full responsibility for all fees required for my dependent's dental needs, regardless of my martial status.
- I understand there is a charge for failing or cancelling an appointment without a 24 hour notice given.
- I understand there is a charge of $35.00 to copy x-rays.
- I understand that there is a charge of $25.00 for any checks returned from my bank, which will be added to my account. I also understand in the event of this happening I will be asked to pay by credit card, cash or money order for the returned amount.
- I understand that I am responsible for any fees, expenses or cost related to the collection of any unpaid balances. Including, but not limited to late charges, referral costs and commission paid to attorneys or collection agencies.

PATIENT/GUARDIAN SIGNATURE:_____

DATE:_____

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Please see the person at the front desk if you are interested in reading the Notice of Privacy Practices. This notice describes how health information about you may be used and disclosed and how you can access this information. Please sign below stating you have read/understand the privacy policy.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature:_____Date:_____
If a personal representatives this authorization on behalf of the individual, complete the following.

Personal Reps Name:_____
Relation to individual:_____

PLEASE ANSWER *ALL* QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

1. Purpose of visit?_____
2. Are you aware of a problem? YES NO
   If yes: are you in pain?_____
3. Previous Dentist: Name_____
4. How long has it been since your last dental visit?_____
5. What was done at that time?_____
6. Do you go regularly to your cleaning appointments? YES NO
7. When was the last time your teeth were cleaned?_____
8. Have you lost or had any teeth removed? YES NO
   If yes, why?_____
   Were they replaced? YES NO
   Are you happy with the replacement? YES NO
9. Have you had dental x-rays taken in the last year? YES NO
10. Have you ever had any problems with a dental treatment? YES NO
    If yes, explain_____
11. Do you clench or grind your teeth? YES NO
12. Do you have any muscle soreness in your face, jaw or ear? YES NO
13. Do you have frequent aches of the head/neck region? YES NO
14. Does food get caught in your teeth? YES NO
15. Are your teeth sensitive to: HOT COLD SWEETS PRESSURE (circle all that apply)
16. Have you ever had gum surgery in the past? YES NO
17. Have you ever had a "deep cleaning" in the past? YES NO
    If yes, how long ago?_____
18. Do your gums bleed or hurt? YES NO
19. Have you ever been informed about periodontal disease? YES NO
20. How often do you brush your teeth?_____
21. Do you floss? _____How often?_____
22. Have any of your teeth become: LOOSE SHIFTED CHIPPED (circle all apply)
23. Are you happy with the appearance of your teeth? YES NO
24. Are you interested in whitening? YES NO
25. Are you interested in straightening your teeth? YES NO
26. Have you had any unpleasant dental experiences in the past? YES NO
    If yes, please
    explain?_____
    _____
    _____

I certify that the above information is true and accurate to the best of my knowledge:

Patient/Guardian signature:_____DATE:_____
Dentist's signature:_____DATE:_____

PATIENT INFORMATION

Please circle one of the following: MALE FEMALE MARRIED SINGLE CHILD

NAME:_____ **BIRTHDATE:**_____

ADDRESS:_____ **APT#:**_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

HOME #:_____ **WORK #:**_____ **CELL#**_____

EMPLOYER:_____ **SS#:**_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

EMAIL ADDRESS:_____

MEDICAL HISTORY

OFFICE/PHYSICIANS:_____

PHONE #:_____

ARE YOU UNDER A DRS. CARE?_____

REASON:_____

ARE YOU TAKING ANY MEDICATIONS, PILLS OR DRUGS?_____

ANY ALLERGIES TO MEDICATIONS OR SUBSTANCES?_____

DO YOU SMOKE? YES NO ARE YOU PREGNANT? YES NO NURSING? YES NO

DO YOU NEED TO BE PREMEDICATED FOR DENTAL TREATMENT? YES NO

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV POSITIVE	COUGH	HEART PACEMAKER	PSYCHIATRIC CARE
ANEMIA	COLD SORES	HEART SURGERY	RHEUMATISM
ARTIFICIAL JOINTS	DIABETES	HAY FEVER	RESPRITORY DISEASE
ARTIFICIAL HEART VALVE	DRUG ADDICTIONS	HEPATITIS A	SHORT OF BREATH
ASTHMA	EPILEPSY	HEPATITIS B	SWELLING
ARTHRITIS/GOUT	EXCESSIVE THIRST	HEPATITIS C	SCARLET FEVER
BLOOD DISEASE	EMPHYSEMA	HYPOGLYCEMIA	SINUS TROUBLE
BLOOD TRANSFUSION	FAINTING	HEMOPHILIA	KIDNEY DISEASE
BACK PROBLEMS	FEVER BLISTERS	HERPES	SICKLE CELL ANEMIA
CANCER	GLAUCOMA	JAW PAIN	TUBERCULOSIS
CONGENITAL HEART LESION	HEADACHES	LOW BLOOD PRESSSURE	ULCERS
CHEST PAIN	HEART MURMER	LUNG DISEASE	VENEREAL DISEASE
CHEMO/RADIATION TXS	HEART TROUBLE	LIVER DISEASE	
CORTISONE TREATMENTS	HIGH BLOOD PRESSURE	MPV	

HAVE YOU EVER HAD ANY OTHER HEALTH PROBLEMS NOT LISTED: YES NO

CONSENT: The undersigned herby authorizes to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be needed. I further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embody a certain risk. I understand that the responsibility for payment for Dental Services provided in this office for myself or my dependents is my responsibility and that payment is due at the time services are rendered. I further understand that finance charges may be added to any account that is 90 days past due. In the event of default I (we) promise to pay interest on the indebtedness, together with reasonable attorney fees and an addition 50% of balance added for collection costs as will be required to effect collection of this account.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

DENTISTS SIGNATURE:_____

STOP...QUESTIONNAIRE FOR OBSTRUCTIVE SLEEP APNEA (OSA)

NAME:_____DATE:_____

This test consists of 4 questions
PLEASE CIRCLE YES OR NO.

1) **SNORING:** DO YOU SNORE LOUDLY(LOUDER THAN TALKING OR LOUD ENOUGH TO BE HEARD THROUGH A CLOSED DOOR?

   YES NO

2) **TIRED:** DO YOU OFTEN FEEL TIRED, FATIGUED OR SLEEPY DURING THE DAY?

   YES NO

3) **OBSERVED:** HAS ANYONE OBSERVED YOU STOP BREATHING DURING YOUR SLEEP?

   YES NO

4) **BLOOD PRESSURE:** DO YOU HAVE OR ARE YOU BEING TREATED FOR HIGH BLOOD PRESSURE?

   YES NO

HIGH RISK OF OSA: answering yes to 2 or more questions

LOW RISK OF OSA: answering yes to less than 2 questions