Sleep Dentistry℠ of PORTLAND & VANCOUVER

Patient information:

Last name:	First name:	Middle:	Suffix *(check):* ☐ Sr ☐ Jr ☐ I ☐ II ☐ III	Pronoun:
Address:	City:	State:	Zip code:	Preferred Name:
Mailing address *(if different):*				Date of birth *(mm/dd/yyyy):*
Cell phone:	Home phone:	Work phone:		SSN:
Email address *(email is not secure):*				
Emergency contact:	Relationship:			Phone number:

Parent or Guardian, if patient is a minor:

Name of parent or guardian *(last, first):*			Relationship:
Mailing address *(if different):*	City:	State:	Zip code:
Cell phone:	Home phone:	Work phone:	
Email address *(email is not secure):*			

Insurance Information:

Insurance Company: _____ Insurance Phone #: _____

Insured's Name: _____ Group No./ Local No. _____ Insured's SSN: _____

Do you have dual coverage? ☐ **yes** ☐ **no**

Insurance Company: _____ Insurance Phone #: _____

Insured's Name: _____ Group No./ Local No. _____ Insured's SSN: _____

Medical Information:

Primary care physician: City/State: Phone number:

Are you currently under a doctor's care? *(check)* ☐ **yes** ☐ **no** If yes, please explain:

Has your primary care physician or surgeon recommended premedication with antibiotics prior to procedures? *(check)* ☐ **yes** ☐ **no** If yes, please explain:

If yes, please explain: _____

Have you ever taken any Bisphosphonate medications? (check) ☐ **yes** ☐ **no** If yes, please explain: _____

(Women only) Are you pregnant or trying to conceive? *(check)* ☐ **yes** ☐ **no** If yes, **due date:** _____ Are you nursing? *(check)* ☐ **yes** ☐ **no**

Are you taking oral contraceptives ☐ **yes** ☐ **no**

I acknowledge that all charges for services rendered are my responsibility. Balances over 30 days will be subject to a 1.5% monthly charge (18% per annual). A fee of $50 will be applied to all returned checks. Any cancellation or rescheduling of an appointment, requires 48 business hour notice, to avoid a minimum fee of $75 per appointment hour.

SIGNATURE _____ DATE _____

PRACTITIONER _____ DATE _____

Substance use and history:

Do you use tobacco? ☐ **yes** ☐ **no** *(check):* ☐ **current** ☐ **past** ☐ **never**

If current, how often and type? _____ How many years of use? _____ If past, quit date? _____

Do you use recreational drugs? ☐ **yes** ☐ **no**

If yes : _____

Current prescription and over the counter medications:

Note: If you need additional space or if you are providing a separate list or document please check box ☐

Medication	Dosage	Frequency	Reason for taking medication

Do you have any known allergies? ☐ **yes** ☐ **no** If yes, please explain: _____

Do you have or have you experienced any of the following medical conditions? Please check all that apply

Heart/Blood Pressure Problems

- ☐ Heart Disease
  - If yes, type: _____
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Ineffective Endocarditis
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valve
- ☐ Heart Murmur
- ☐ Arrhythmia
- ☐ Pacemaker
- ☐ Implantable Defibrillator
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Other: _____

Respiratory/Lung Problems

- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Sleep Apnea
- ☐ Other: _____

Endocrine Disorders

- ☐ Diabetes
  - if yes, type: _____
  - Last HbA1c Reading
  - Date Taken: _____
- ☐ Insulin Pump
- ☐ Thyroid Disease
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Parathyroid Disease
- ☐ Other: _____

Kidney/Liver Disease

- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Hepatitis
  - if yes, type: _____
- ☐ Liver Disease
- ☐ Other: _____

Blood Disorders

- ☐ Anemia
- ☐ Bleeding Disorder
  - if yes, type: _____
- ☐ Blood Thinners
- ☐ High Cholesterol
- ☐ Other: _____

Stomach/Intestine Disorders

- ☐ Special Diet
  - if yes, type: _____
- ☐ Ulcers
  - if yes, location: _____
- ☐ Acid Reflux
- ☐ Crohn's Disease
- ☐ Other: _____

Infectious Diseases

- ☐ HIV/AIDS
- ☐ MRSA *(check)* Active Inactive
  - if yes, location: _____
- ☐ Cold Sores
- ☐ Human Papillomavirus (HPV)
- ☐ Tuberculosis If yes, date treatment ended: _____

Neurologic/Psychiatric Problems

- ☐ Stroke
  - if yes, date: _____
- ☐ TIA (transient ischemic attack)
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Anxiety
- ☐ Dental Anxiety
- ☐ Depression
- ☐ Post-Traumatic Stress Disorder
- ☐ Epilepsy or Seizures
- ☐ Autism Spectrum Disorder
- ☐ ADHD/ADD
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Psychosis
- ☐ Migraines
- ☐ Fainting or Dizzy Spells
- ☐ Other: _____

Cancer/Oncology

- ☐ Cancer
  - if yes, type: _____
- ☐ Chemotherapy
  - if yes, date: _____
- ☐ Radiation Therapy
  - if yes, date: _____

Muscle/Bone/ Connective Tissue Disorders

- ☐ Artificial Joints
  - Joint: _____
  - Date Placed: _____
- ☐ Arthritis
  - if yes, type: _____
- ☐ Osteoporosis
- ☐ Gout
- ☐ Temporomandibular Joint Disorder
- ☐ Fibromyalgia
- ☐ Other: _____

Head/Ear/Nose/Throat Problem

- ☐ Vision Problems
- ☐ Wear Contact Lenses
- ☐ Glaucoma
- ☐ Hearing Impairment
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Other: _____

Eating Disorders

- ☐ Bulimia
- ☐ Anorexia
- ☐ Other: _____

Other

- ☐ Transplanted Organ(s)
- ☐ Implantable Medical Electronic Device
  - if yes, type: _____

Have you ever had any illness or disorder not listed above? ☐ **yes** ☐ **no** If yes, please explain: _____

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 my medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

Sleep Dentistry℠ of PORTLAND & VANCOUVER

Written Financial Policy

Thank you for choosing Sleep Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, Discover and American Express
- Payment Plans[2] from CareCredit and Sunbit
    - Allow you to pay over time with NO INTEREST[1]
    - Convenient, low monthly payment plans[2] also available
    - No annual fees or pre-payment penalties
- 5% discount to seniors without insurance; age 65+ for payments made with cash/check

Please note:

For sedation or more comprehensive treatment plans pre-payment is required. A deposit is required to secure your initial treatment appointment.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

A minimum fee of $75 per hour is charged for patients who miss or cancel an appointment without at least 48-hour business notice.

Sleep Dentistry charges $50 for returned checks.

There is a $25 fee for electronic transfer of dental records.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

I acknowledge that all charges for services rendered are my responsibility. Balances over 30 days will be subject to a 1.5% monthly charge (18% per annual).

Signature Date

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required. [2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

PRIVACY PRACTICES ACKNOWLEDGMENT

I_____, have reviewed the Notice of Privacy Practices for this office. A physical copy is available upon request.

Due to patient confidentiality laws, Sleep Dentistry does not release any information verbally or in writing to anyone other than the patient without prior consent. In order to communicate with our patients about upcoming events, special offers or appointments, we may send postcards, emails, newsletters or leave voice mail messages. **Emails are not encrypted and do not require downloads**.

At times, patients may wish to have information on their health record (lab reports, medications, appointment times, billing questions etc.) discussed with other individuals such as family or caretakers. Please indicate below any persons with whom you would like to allow us to share information with regarding your treatment (Minors 15 years of age or older must also designate with whom health information may be shared).

I allow Sleep Dentistry to release protected health information to:

PERSON	RELATIONSHIP
_____	_____
_____	_____
_____	_____

_____ _____

Patient Signature **Date**

++OFFICE USE ONLY++

□ Individual refused to sign
□ Communication barriers prohibited obtaining acknowledgment
□ An emergency situation prevented us from obtaining acknowledgment

NOTES:_____