Welcome to **The Dental Care Group**, a general practice and multi-specialty dental group. Please take a moment to review our office policy regarding Dental Plans and Dental Insurance so that you may receive all of the benefits you are entitled to.

HOW YOUR DENTAL PLAN & INSURANCE WORKS:

Your dental plan and insurance entitles you to quality dental care at considerably reduced fees, often 50-60% below our usual and customary fees for the same service.

- **Many Services** are covered completely by your plan or insurance, each case is different. Refer to your dental plan or insurance book for benefits.
- For our Dental Plan Patients, some services are listed specifically on your Dental Plan Fee Schedule with a **fee mandated by your plan** and accepted by our office. These are your financial responsibility and investment for these services. (Even so, these fees are usually 50-60% below our regular fees.) **Other Services** are not listed at all on the Dental Plan fee schedule and are therefore **not a covered expense** on your plan. These services are available to you at a reduced fee designated by your plan. These "net" fees are your financial obligation and investment for these services.

The Doctor and /or the treatment coordinator will discuss all treatment and explain your estimated financial responsibility for the investment on your dental work before the services are rendered. Treatment plans are subject to change. If you have any questions our treatment coordinators will be happy to answer them.

You have five obligations in order to receive these benefits under your plan at our office:

1. It is your obligation to verify with your Insurance Company that the doctor/doctors who are treating you are in network.
2. You must bring your Dental Plan or Insurance ID Card and other form of identification (preferably a photo ID) to every visit.
3. **You must keep your reservations**. If you happen to make a change to your reservation less than 48 hours in advance or if you just don't show up you **will be charged a broken reservation fee**. Long reservations will require a deposit and if you happen to make any changes to your reservation less than 48 hours in advance we **will forfeit your reservation deposit**.
4. You must be prepared to pay in full for each service on the day that the service is performed. Please understand that we cannot render services at extremely reduced fees and not receive immediate payment, therefore, **all charges are due at the time that the treatment is performed**. Multi-visit procedures may be paid in equal installments. If there is an outstanding balance for treatment already completed then no further treatment, including fully covered treatment, will be rendered until the balance due is paid in full. **"Please ask us about our Interest Free Payment Plans".**
5. If your plan mandates a "Sterilization Fee" or "Office Visit Fee" per visit, you must pay that fee at each visit.

If you have any questions about your Dental Plan or Dental Insurance please feel free to ask the treatment coordinator or any team member. It is our goal to help you and your family receives the maximum benefits from your Dental Plan or Dental Insurance while providing you and your family with quality care and state of the art technology. Let's work together towards that goal.

_____ _____

Date **Patient Signature**

Patient Registration **Date:** _____

First Name:_____ Last Name:_____Birth date: _____

Social Security #: _____ Sex: ❍ Female ❍ Male ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

Address: _____

Home Phone: _____Work Phone:_____Cell Phone: _____

Email: _____

Occupation: _____ Referred By: _____

Primary Insurance Information: **Person Responsible for Payment:** _____

Name of Subscriber: _____ Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Subscriber ID: _____ Group ID: _____

Subscriber's Social Security #: _____ Subscriber's Birth date: _____

Employer/Group Name:_____ Insurance Company: _____

Address: _____ Insurance Phone: _____

MEDICAL HISTORY

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, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	_____
Do you use controlled substances?	Yes	No	_____
Do you take aspirin daily?	Yes	No	_____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other If yes, please explain: _____

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

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

Have you ever had any serious illness 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 medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

HIPAA/General Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby consent to the use and/or disclosure of my protected health information by The Dental care Group for the purposes of treatment, payment and healthcare operations.

I certify that all the information provided is correct and I understand that I am responsible for all cost of Dental Treatment.

I understand that protected health information includes the following:

- Health records describing my health history, symptoms
- Demographic information
- Examination and test results
- Diagnosis
- Treatment
- Plans for future medical care

And that this information serves as:

- A means for communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A basis for diagnosing and planning my care and treatments
- A means by which a third party can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I further understand that:

1. The Dental Care Group originates and maintains protected health information as part of my healthcare, including but not limited to information that may have been obtained from another healthcare provider, clearinghouse, health plan or employer.
2. I have the right to review The Dental Care Group Notice of Privacy Practices (which describes The Dental Care Group protected health information use and disclosure practices) before I sign this document.
3. I have the right to request a restriction as to how my protected health information is used to carry out treatment, payment or health care operations, however, The Dental Care Group is not required to agree to the restrictions requested.
4. I have the right to revoke this consent at any time in writing. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon.
5. The Dental Care Group reserves the right to change Notice of Privacy Practices at any time. I have the right to obtain a copy of any revised notice upon request.
6. It is your obligation to verify with your insurance company that the doctor/doctors who are treating you are in network.
7. You must be prepared to pay in full for each service on the day that the service is performed.
8. 48 hr. notice is required for any changes made to your dental reservation or you may be subject to a broken reservation fee.
9. **Long reservations will require a deposit.**
10. The Treatment Coordinator will discuss all treatment and explain any estimated charges to you before services are rendered.

Restrictions:

❍ No restrictions requested

❍ I request the following restrictions(s) on the use or disclosure of my health information:

_____

_____

Patient Name (printed): _____

_____ _____

Signature of Patient or Parent/Legal Guardian | Date

_____ _____

If Parent/Legal Guardian Signed, then Printed Name Here | Relationship to Patient *(if applicable)*

Restriction ❑ Accepted ❑ Denied

FOR OFFICE USE ONLY

Our purpose in conducting this **NEW PATIENT INTERVIEW** is to learn more about you, allowing our team to supply you with all of the important information you will need to make informed decisions regarding your overall health.

PATIENT INFORMATION:

Date of visit: _____ Scheduled date:_____
Patient: _____ Referred by: _____
Spouse: _____ Children: _____
Doctor: _____

BUILDING RELATIONSHIPS:

1. We like to treat our patients like family. Before we get to your oral health, we like to get to know you. What would you like to share with us about yourself? Family? Career? Fun?

2. What would you like to know about our dental practice? Doctor(s)? , Hygienist(s)? , Assistant(s)?

3. What are your thoughts about going to the dentist? What were your previous dental experiences like?

4. What dental problems have you had in the past? Currently experiencing?

5. What do you like/ dislike about your teeth (are your teeth as you would like them to be)?

6. Which of the following values are most important to you in regards to your treatment?
☐ Cosmetic ☐ Comfort ☐ Function ☐ Longevity

7. Do you ever experience frequent headaches, neck or back pain? □ Yes □ No

8. To ensure that we serve you personally and comfortably, which of the following are most important to you?

☐ A clear understanding of your dental problems and recommended solutions
☐ To know absolutely everything that is going on in your mouth, regardless of its severity
☐ To be called after your visit to see how you are doing
☐ To be done with treatment sooner with longer appointments or
☐ Multiple shorter appointments to complete treatment
☐ Would you prefer a ☐ Call ☐ Text or an ☐ Email to remind you of your appointment time

9. We provide a **Complimentary Comfort Menu**, would you like any of the items listed here? ☐ Free WIFI
☐ Neck Pillow ☐ Headphones ☐ Blanket ☐ Bottle water ☐ Dark glasses ☐ Lip Balm ☐ iPad ☐ Hand Towel

10. We ask our patients to pay at the time services are rendered or before. What method of payment is best for you?
☐ Cash ☐ Check ☐Credit Card ☐Interest-free financing

SleepArchiTx™

Sleep Disorder Assessment

FAX 888-388-8178 | diagnose@sleeparchitx.com

Dental Care Group

Full Name | Practice Name

Home Address | City, State ZIP Code

Mobile Phone | E-mail Address

☐ Female ☐ Male

Date of Birth | Gender (*check off*)

Complete the following questionnaire to the best of your abilities by circling the answer to each question. Answers to these questions will help us determine how well you rest at night and the likelihood that you might be suffering from a life-threatening condition.

1.	**Has anyone told you that you stop breathing while asleep?** *If yes, who? How often? (daily, weekly, etc.)*	Y	N	4
2.	**Have you ever been involved in any type of accident because you nodded off or fell asleep?** *If yes, tell us more.*	Y	N	3
3.	**Have you ever nodded off or fallen asleep while driving?** *If yes, how often? When was last time?*	Y	N	3
4.	**Have you woken up suddenly gasping for air, heart racing or with shortness of breath?** *If yes, how often? (daily, weekly, etc.)*	Y	N	3
5.	**Do you grind your teeth?** *If yes, have doctor circle dental wear severity: mild moderate severe*	Y	N	3
6.	**Do you snore or has someone ever told you that you snore?** *If yes, how often? (daily, weekly, etc.)*	Y	N	3
7.	**Does anyone in your family have a history of snoring or sleep apnea?** *If yes, who? Snoring or sleep apnea?*	Y	N	3
8.	**Do you feel tired or sleepy throughout the day?** *If yes, how often? (daily, weekly, etc.)*	Y	N	2
9.	**Does it take you less than 10 minutes to fall asleep?** *If yes, how many minutes?*	Y	N	2
10.	**Does it take you more than 20 minutes to fall asleep?** *If yes, how many minutes?*	Y	N	2
11.	**Once you fall asleep, do you have trouble staying asleep?** *If yes, tell us more.*	Y	N	2
12.	**Do you find it difficult to manage your weight?** *If yes, tell us more.*	Y	N	1
13.	**Do you suffer from headaches during the morning or during the night?** *If yes, how often? (daily, weekly, etc.)*	Y	N	1

MEDICAL HISTORY

14.	**Have you been diagnosed with high blood pressure or take medication for it?**	Y	N	3
15.	**Do you suffer from acid reflux?**	Y	N	3
16.	**Do you suffer from heart disease or have you had a stroke?**	Y	N	3
17.	**Have you been diagnosed with a sleep disorder?**	Y	N	3
18.	**Have you stopped using your CPAP device?**	Y	N	3
19.	**Are you wearing your CPAP less than 5 times per week?**	Y	N	3
	Please add the total values corresponding to your YES answers:			

Based on the total number you entered above, circle the Risk Level listed below.

RISK LEVEL	LOW RISK	MODERATE RISK	HIGH RISK	SEVERE RISK
RANGE TOTAL	0 TO 3	4 to 5	6 to 7	8 +

Patient Signature:

SDAv5