Cardinal Park
FAMILY DENTAL CARE

Patient Name: _____ Date: _____

In our continuing effort to improve and monitor the health of our patients, we are asking you to participate in answering a few questions that may determine your susceptibility to Sleep Apnea. Our team of doctors have been monitoring and following trends in todays medicine that will help assist in the diagnosis and early treatment of Sleep Apnea.

Epworth Sleepiness Scale

This scale is used to determine the level of daytime sleepiness. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:

0= would *never* doze or sleep
1= *slight* chance of dozing or sleep
2= *moderate* chance of dozing or sleeping
3= *high* chance of dozing or sleeping

Situation

Sitting and reading	_____
Watching TV	_____
Sitting in an inactive public place	_____
Being a passenger in a vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total Score (add the scores up)	
This is your Epworth Score	_____

Welcome

TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Cell Phone #1 (____) _____ Cell Phone #2 (____) _____

Employer/School _____ Employer/School Phone (____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (____) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints, Pins, etc.
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

_____

_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

CARDINAL PARK FAMILY DENTAL CARE & YOUR INSURANCE PLAN

HOW THEY WORK TOGETHER

The staff at **Cardinal Park Family Dental Care** is pleased that you have insurance benefits to help you with the cost our dental care. We would like to help you obtain the maximum use of these benefits; so with this in mind, please read the information regarding our policy on dental benefits.

DO YOU ACCEPT MY INSURANCE? If your insurance plan allows you the freedom to choose your own doctor, then you can use your benefits in our office-WE ARE NOT A PROVIDER FOR *ANY* INSURANCE THOUGH. We are happy to file your claim for you, and will accept the assignment of benefits if your plan allows. Accepting assignment of benefits does not mean that we accept whatever the insurance company pays as full payment. Most insurance plans require the patient to pay a deductible, and a portion of the bill.

HOW MUCH WILL THEY PAY? We have the opportunity to verify your dental insurance coverage and obtain an approximate breakdown of benefits, we are able to estimate your payment portion based on the information we receive, but it is **ONLY AN ESTIMATE**. Please understand that we do not have a contract with any insurance company; therefore it is impossible to give you a guarantee of what the insurance company will pay at the time of service. If we are unable to verify your insurance coverage, you are responsible for payment in full of all fees associated with your treatment at each visit.

If you want to determine what your insurance company will pay, we are happy to file a pre-treatment authorization with your insurance company prior to treatment. This may delay treatment, but will give you the exact out of pocket figure you require.

INSURANCE DIDN'T PAY, NOW WHAT? Ultimately, you are responsible for all charges incurred in our office. We file your insurance claims as a courtesy to you. It is important that you recognize the insurance you have is a legal contract between YOU and YOUR insurance company. Our office is not, and cannot be a part of that legal contract. If your insurance company does not pay a claim within 60 days, Cardinal Park reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. Additionally, dental insurance is designed to defray the cost of your dental treatment. It is not intended as a total payment for services and should not be used to determine the type of amount of treatment you receive.

I THOUGHT I PAID MY PORTION BUT STILL OWE MORE; WHY? We based your estimated out of pocket expense on the benefit verification we receive from your insurance company, but there are many factors that can affect this estimate. There may be an annual deductible that must be met (individual or family), or you may have received treatment in another office prior to joining **Cardinal Park**. Also, you might need to see a specialist for care, which may use a portion or all of you annual maximum dental benefits. Further, insurance companies do not (and cannot in most cases) notify **Cardinal Park** of changes to your benefits, they only notify you. If any of these situations apply to you, please let us know as soon as possible.

WHAT IS UCR? UCR stand for Usual, Customary, and Reasonable. It is a term created by insurance companies to define what they are willing to pay for a particular procedure.

ASSIGNMENT OF BENEFITS

I authorize my insurance company to pay the office of **Dr. Ashton** all benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance claim submissions.

I authorize the office of **Dr. Ashton** to release all information necessary to secure payment of insurance benefits.

I understand that I am financially responsible for all fees regardless of whether or not they are covered by insurance.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at **Cardinal Park.**

Parent/Guardian Signature_____Date_____

CARDINAL PARK FAMILY DENTAL CARE
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name:_____ Date of Birth:_____

TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Office Manager. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURES

I, _____, have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____
Relationship to Patient:_____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____
Relationship to Patient:_____