DIVINEEXPRESSIONS
FAMILY DENTISTRY

Welcome

Thank you for selecting Divine Expression Family Dentistry! We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask. We will be glade to help.

Patient Registration:

Name: _____ Birthdate: _____

Address:_____ City:_____ State:___Zip:_____

Sex □ M □ F □ Single □ Married □ Separated □ Divorced □ Widowed

Phone: (___)_____ Alt Phone: (___)_____Work Phone: (___)_____ Ext: _____

E-Mail:_____ Social Security: _____

Employment Status: □ Full Time □ Part Time □ Retired **How did you hear about us:_____**

Occupation:_____ Company:_____

Student Status: □ Full Time □ Part time

Primary Care Physician: _____ Phone:_____

Pharmacy Name: _____ Phone:_____

Insurance Information:

Insurance Company: _____ Member ID: _____ Group #:_____

Claims Address:_____ City:_____ State:____ Zip:_____

Name of Insured: _____ Birthdate: _____ Social Security:_____
Relationship: □ Self □ Spouse □ Child □ Other

Emergency Contact:_____ Phone Number: (___)_____

Dental History:

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

Check (√) If you have had problems with any of the following:

□ Bad Breathe	□ Grinding Teeth	□ Sensitivity to hot
□ Bleeding Gums	□ Loose teeth or broken fillings	□ Sensitivity to sweets
□ Clicking or popping jaw	□ Periodontal Treatment	□ Sensitivity when biting
□ Food collection between teeth	□ Sores or growths in mouth	□ Sensitivity to cold

How often do you floss: _____ How often do you brush:_____

Medical History:

Check (√) If you have had any of the following:

□ Anemia □ Congenital Heart Lesions □ Hepatitis □ Scarlet Fever □ Arthritis, Rheumatism

□ Cortisone Treatments □ Hernia Repair □ Shortness of Breath □ Artificial Heart Valves □ Asthma

□ Cough, Persistent □ High Blood Pressure □ Skin Rash □ Artificial Joints, Pins, Etc. □ HIV/AIDS

□ Cough up blood □ Stoke □ Back Problems □ Epilepsy □ Kidney Disease □ Fainting

□ Bleeding Abnormally □ Swelling of feet or Ankles □ Liver Disease □ Tobacco Habit □ Cancer

□ Headaches □ Pacemaker □ Tonsillitis □ Chemical Dependency □ Heart Murmur □ Ulcer

□ Tuberculosis □ Radiation Treatment □ Chemotherapy □ Heart Problems □ Respiratory Disease

□ Heart Problem □ Venereal Disease □ Circulatory Problems □ Hemophilia □ Rheumatic Fever

Have you ever had any serious illnesses or operations? □ Yes □ No *If **yes**, describe:*_____

(Women) Are you pregnant? □ Yes □ No **Nursing?** □ Yes □ No **Taking birth control?** □ Yes □ No

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 is my responsibility to inform my doctor if I, or my minor child, ever have a change in heath.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to 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*

Current Sleep Disordered Breathing Treatment:

Have you been prescribed a C-PAP to manage your sleep-related breathing disorder (apnea)? □ **Yes** □ **No**

If answered "No" Please skip down to Epworth Sleepiness Scale.

If yes, do you wear your C-PAP as prescribed? □ **Yes** □ **No**

If you **do not** wear your C-PAP as prescribed, check **(√)** the reason(s) below:

□ Mask Leaks □ Mask/device is uncomfortable □ Noise disturbs sleep and/or bed partner's sleep

□ Movement is restricted during sleep □ Straps/headgear cause discomfort □ Claustrophobia

□ Does not seem to be effective □ Pressure on the upper lip causes tooth related problems

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

Scoring:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation:	With CPAP / Without CPAP
1. Sitting and reading	_____ /_____
2. Watching TV	_____ / _____
3. Sitting inactive in a public place (i.e a theather or meeting)	_____ / _____
4. As a passenger in a car for an hour without a break	_____ / _____
5. Lying down to rest in the afternoon when circumstances permit	_____ / _____
6. Sitting and talking to someone	_____ / _____
7. Sitting quietly after lunch without alcohol	_____ / _____
8. In a car, while stopped for a few minutes in traffic	_____ / _____
Total Score:	_____ / _____

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Dental Survey

Tell Us About Your Smile

Please take a moment to tell us about your smile so that we may better serve your individual needs.

When I see a picture of myself, the first thing I notice about my smile is:

_____.

Some things that I consider attractive in other people's smiles are:

_____.

Please place a "√" next to the statements below that apply to you.

- o I wish my teeth were straighter.
- o I wish I had a broader smile.
- o I think some of my teeth are too small.
- o I think some of my teeth are too large.
- o I wish my teeth were whiter with regard to their color.
- o I think my gums show too much when I smile.
- o I think my smile shows too much space between some of my teeth,
- o Because I am not totally pleased with my teeth, I sometimes hesitate to smile.
- o I feel as though I don't really know all of the options available to me for enhancing my smile.
- o Concerns over fees have prevented me from taking advantage of some of the available options to enhance my smile.
- o I feel as though I could do a better job of protecting the health of my teeth and gums, and therefore, the longevity of my smile.

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Thank you for choosing Divine Expressions Family Dentistry! Our goal here at Divine Expressions is to provide our patients with the quality of dentistry that we require ourselves. We believe that communication is paramount to a healthy doctor/patient relationship. Please carefully read and initial acknowledging the practice policies. We look forward to taking care of all your dental needs! ***Please read and initial each statement.***

- ____ I understand that co-pays and payments are due prior to the beginning of treatment.
- ____ I understand that return checks will be accessed a fee of $30.00.
- ____ I understand that in the event of non-payment, or default, the patient/guardian will be responsible for all costs of collection, in addition to the outstanding balance.
- ____ I understand and agree to give 24-hour cancelation notice for any appointment made otherwise I will be charged $55.00.
- ____ I understand that if I am unable to make my appointment time within a 15-minute window, Divine Expressions reserves the right to reschedule my appointment.
- ____ I understand that If I require a prescription for sedation for dental anxiety, I am required to bring a driver, otherwise my appointment will be rescheduled.
- ____ I understand that I cannot drop my minor child, under 14, off for dental treatment nor can I leave once the procedure starts. Any child over 14 is able to give consent for treatment.
- ____ I understand that I must also give verbal confirmation or leave a message on the voicemail, otherwise my appointment will be rescheduled.
- ____ I understand that cell phone usage is not permitted in the treatment area.
- ____ I understand that if my insurance provider has not paid after 60 days of my treatment the balance is due by me.

By signing I agree that I have read all understand the office polices of Divine Expressions Family Dentistry to ensure I receive the best possible care.

Signature :_____ Date: _____

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Media & Social Release Form

As a part of a vibrant company, we like to promote patient and office activities and celebrate achievements from time to time on social media and other outlets.

I, _____ (**please print**), do hereby consent and agree that Divine Expressions Family Dentistry, its employees, or agents have the right to take photographs, videotape, or digital recordings of me and to use these in any and all media, now or hereafter known, and exclusively for the purpose of advertising, education and other promotions. I further consent that my name and identity may be revealed therein or be descriptive text or commentary. I do hereby release to Divine Expressions Family Dentistry its agents, and employees all right to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I wave any rights/claims/ or interest I may have to control the use of my property of Divine Expressions Family Dentistry. I understand that there will be no financial or other remuneration or recording me, either for initial or subsequent transmission or playback. I also understand that divine Expressions Family Dentistry is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result. I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

We do acknowledge that any patients that are under 18 years of age may not sign this without their parent present or their parent's permissions. If you are a parent signing this for your child, please enter their name into the space provided below.

The Health Insurance Portability and Accountability Act still holds its place and I have been informed that absolutely no medical information will be released without the signing of this form.

- *I refuse to release Divine Expressions Family Dentistry the right to take photographs, videotape, or take digital recordings of me to use in any and all media outlets.*

Name: _____

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices:

** You may refuse to sign this acknowledgement**

I have been shown a copy of this office's **Note of Privacy Practices & HIPPA** and can obtain a hard copy upon request.

Signature: _____ Date: _____