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. For example, we might make a social media post like:

"Congratulations to our No Cavity Club member, (Patient Name) for completing yet another cavity free hygiene appointment! You are on your way to getting a big prize and a lifetime of good dental health!" (This post may include a picture with the patient and their hygienist)

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 by descriptive text or commentary. I do hereby release to Divine Expressions Family Dentistry its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used. All negatives, prints, digital reproductions shall be property of Divine Expressions Family Dentistry. I understand that there will be no financial or other remuneration for 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 parents' permission. If you are a parent signing for your child, please enter their name in the spaces 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 release with 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 and to use in any and all media outlets.

Name: ____

Signature: ____ Date__________

Divine Expressions Family Dentistry
Dr. Laurentis L. Barnett
7185 Highway 72 West, Suite C
Madison, AL 35758
256-837-1200

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- I understand that I must also give a 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 and understand the office policies of Divine Expressions Family Dentistry to ensure I receive the best possible care.

_______________________ Signature

_______________________ Date

Patient Name: ______________________________ Date: ____________
First *Middle* *Last*

EPSS 00

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	*Pre-OAT / With OAT
1.	Sitting and reading	___/___
2.	Watching TV	___/___
3.	Sitting inactive in a public place (i.e. a theater or a 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:	___/___

*Pre-OAT areas do not change

Key Reference
Johns, M. (1991). A New Method for Measuring Daytime Sleepiness: The Epworth Sleepiness Scale. *Sleep,* 540 - 545.

MEDICATIONS AND CONDITIONS

Please list all medications/treatments you are currently taking and the reason you take them. (Include all over-the-counter medications, vitamins, herbs, etc.)

Medication	Dosage	Reason for Taking

Treatment	Doctor/Provider Name	Approximate Date of Treatment

Pharmacy Name: ______________________________

Pharmacy Phone Number: ________________________

CURRENT SLEEP DISORDERED BREATHING TREATMENT

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

If you have not been prescribed a C-PAP, please move ahead to the **RELEASE OF FINDINGS** section.

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
- ☐ Unable to sleep comfortably
- ☐ Noise disturbs sleep and/or bed partner's sleep
- ☐ Movement is restricted during sleep
- ☐ Other
- ☐ Straps/headgear cause discomfort
- ☐ Claustrophobia
- ☐ Latex allergy
- ☐ Does not seem to be effective
- ☐ Pressure on the upper lip causes tooth related problems

RELEASE OF FINDINGS

I authorize the release of all examination findings and diagnosis, reports and treatment plans, to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient Signature: ____ Date: ______________

ALLERGIC REACTIONS

Please check any and all medications or substances that have caused an allergic reaction.

- ☐ Anesthetics
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Metals
- ☐ Codeine
- ☐ Iodine
- ☐ Barbituates
- ☐ Sedatives
- ☐ Penicillin
- ☐ Plastic
- ☐ Latex
- ☐ Sulfa

Other: ____________________

HEALTH AND MEDICAL HISTORY (Social)

- ☐ Yes ☐ No Are you currently pregnant?
- ☐ Yes ☐ No Had prior orthodontic treatments
- ☐ Yes ☐ No Have you sustained injury to:
  ☐ Head ☐ Neck ☐ Face ☐ Teeth
- ☐ Yes ☐ No Do you smoke tobacco?
- ☐ Yes ☐ No Do you drink 4 or more cups of coffee per day?
- ☐ Yes ☐ No Do you consume alcohol and/or sedatives?

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

- ☐ Yes ☐ No Fibromyalgia
- ☐ Yes ☐ No Hypertension
- ☐ Yes ☐ No Chronic fatigue syndrome
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Bleeding easily
- ☐ Yes ☐ No Bruising easily
- ☐ Yes ☐ No Difficulty concentrating
- ☐ Yes ☐ No Difficulty breathing while sleeping
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Gastroesophageal reflux (GERD)
- ☐ Yes ☐ No Frequent night waking
- ☐ Yes ☐ No Heart attack
- ☐ Yes ☐ No Difficulty concentrating
- ☐ Yes ☐ No Arterial Hypertension
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Urinary tract disorder
- ☐ Yes ☐ No Swollen, stiff or painful joints
- ☐ Yes ☐ No Shortness of breath
- ☐ Yes ☐ No Sinus problems
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Recent weight gain
- ☐ Yes ☐ No Migraines
- ☐ Yes ☐ No Insomnia
- ☐ Yes ☐ No Frequent morning sore throat
- ☐ Yes ☐ No Memory loss
- ☐ Yes ☐ No Coronary Artery Disease (CAD)
- ☐ Yes ☐ No Chronic Heart Failure (CHF)

Additional condition(s): ____________________

Mouth and Nose Related Conditions

- ☐ Yes ☐ No Dry mouth
- ☐ Yes ☐ No Frequent snoring
- ☐ Yes ☐ No Broken tooth
- ☐ Yes ☐ No Trouble breathing through nose
- ☐ Yes ☐ No Jaw locking
- ☐ Yes ☐ No Chronic sinusitis
- ☐ Yes ☐ No Burning tongue
- ☐ Yes ☐ No Frequent biting of the cheek
- ☐ Yes ☐ No Jaw pain
- ☐ Yes ☐ No Teeth grinding (Bruxism)

Sleep Conditions

Please select answers based on your average sleep experience and/or what a sleep partner has told you.

- ☐ Yes ☐ No Is it easy to fall asleep?
- ☐ Yes ☐ No Do you feel rested upon AM waking?
- ☐ Yes ☐ No Stopped breathing during sleep?
- ☐ Yes ☐ No Have you ever had a sleep study?
- ☐ Yes ☐ No Do you wake often during the night?
- ☐ Yes ☐ No Gasping or choking during sleep?

Sleep Positions: ☐ Side ☐ Back ☐ Stomach ☐ Varies Average hours of sleep per night? ________

SURGICAL HISTORY

Have you had any of the following?

- ☐ Yes ☐ No General anesthesia
- ☐ Yes ☐ No Adenoids removed
- ☐ Yes ☐ No Tonsils removed
- ☐ Yes ☐ No Jaw joint surgery
- ☐ Yes ☐ No Orthognathic surgery
- ☐ Yes ☐ No Oral surgery
- ☐ Yes ☐ No Removal of third molar (wisdom teeth)
- ☐ Yes ☐ No Other surgery

Other types of surgery: ____________________

____

HISTORY OF SYMPTOMS (Family)

On what date, or approximate date, did the chief complaint condition or symptoms first occur? ____________

Does any family member have the same or similar problem? ☐ Yes ☐ No If yes, please explain: ____________

____

Can you relate your pain or condition to a motor vehicle accident or traumatic injury? ☐ Yes ☐ No

Patient Health Questionnaire

PATIENT INFORMATION

Today's Date: ________________

Name: ______________________________ (First / Middle / Last) Date of Birth: ________________

Address: ________________ City: ________________ State: ______ Zip: ________

Home Phone: ________________ Alternate Number: ________________

Occupation: ________________ Company: ________________

Dentist: ________________ Phone: ________________

Physician: ________________ Phone: ________________

CHIEF COMPLAINT

Circle the chief complaint and place a check mark next to all other symptoms you are experiencing.

___ Headache
___ Ear pain
___ Jaw pain
___ Pain when chewing
___ Facial pain
___ Throat pain
___ Neck pain
___ Limited ability to open mouth
___ Jaw joint locking
___ Jaw joint noises
___ Ear congestion
___ Sinus congestion
___ Dizziness
___ Tinnitus (ringing in the ears)
___ Muscle twitching
___ Vision problems
___ Teeth grinding
___ Kicking or jerking leg repeatedly
___ Swelling in ankles or feet
___ Morning hoarseness
___ Dry mouth upon waking
___ Fatigue
___ Difficulty falling asleep
___ Tossing and turning frequently
___ Repeated awakening
___ Feeling unrefreshed in the morning
___ Significant daytime drowsiness
___ Frequent heavy snoring affects sleep of others
___ Gasping when waking
___ Told that I stop breathing during sleep
___ Night-time choking spells
___ Unable to tolerate C-PAP
___ Teeth crowding

Other: ______________________________

Do you have concerns in any of these areas: ☐ Appearance ☐ Bite ☐ None ☐ Ability to chew ☐ Smile ☐ Snoring

Other comments: ______________________________

Do any of the above complaints or concerns affect your daily life? ______________________________

What kind of results are you hoping to achieve from treatment? ______________________________

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____________________ ____________________

Signature Date