ROYAL OAK DENTAL GROUP

PATIENT HEALTH & DENTAL HISTORY

Full Name_____Date of Birth_____SS#_____
Address_____City & State_____Zip Code_____
Home Phone_____Business_____Emergency_____
Mobile Phone_____E-Mail Address_____
Person to Notify in Case of Emergency_____Relationship_____
Name & Address of Closest Living Relative Not Living with You_____
_____
Place of Employment_____
Driver's License #_____State Issued_____
Sex: ◯ M ◯ F Marital Status_____ Physician's Name_____
May we send you email and text messages? ◯ Yes ◯ No
Which do you prefer? ◯ Email ◯ Text messages

Dental Benefit Policy Holder _____
Dental Benefit Company _____

Whom May We Thank for Referring You to Our Office_____

Responsible Party ***(required for patients under 18 or if someone other than the patient)*****:**
Person Responsible for Account_____Relationship to Patient_____
Phone #_____Email_____ SS#_____
Street Address_____

PLEASE CHECK THE CORRECT RESPONSE AND ANSWER ALL QUESTIONS

Are you taking any medication now, including regular dosages of aspirin? ◯ Yes ◯ No
If so, please list name and dosage_____
(Use page 3 if needed to list all medications)
Are you aware of having an allergic reaction to any medication or substance? ◯ Yes ◯ No
If so, please list_____
Have you been under the care of a medical doctor during the past two years? ◯ Yes ◯ No
If so, for what?_____
Have you seen an ENT (ear, nose and throat doctor)? ◯ Yes ◯ No Name_____
Have you seen a chiropractor? ◯ Yes ◯ No Name_____
Have you seen a neurologist? ◯ Yes ◯ No Name_____

Indicate which of the following you have or have had in the past. Check "yes" or "no" to each.

Heart Concerns	◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No
Congenital Heart Disease	◯ Yes	◯ No	AIDS/HIV	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No	Drug/Alcohol Abuse	◯ Yes	◯ No
High Blood Pressure	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Mitral Valve Prolapse	◯ Yes	◯ No	Neurological Disorders	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Psychiatric/Psychological	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No	Posture Problems	◯ Yes	◯ No

Stroke	◯Yes ◯No	Facial Pain	◯Yes ◯No
Asthma	◯Yes ◯No	Sensitive Teeth	◯Yes ◯No
Liver disease/jaundice	◯Yes ◯No	Neck Ache	◯Yes ◯No
Latex Sensitivity	◯Yes ◯No	Bell's Palsy	◯Yes ◯No
Cold Sores	◯Yes ◯No	TB	◯Yes ◯No
Artificial Joints	◯Yes ◯No	Trigeminal Neuralgia	◯Yes ◯No
Kidney Trouble	◯Yes ◯No	Tingling in arms/fingers	◯Yes ◯No
Radiation/Chemotherapy	◯Yes ◯No	Insomnia/frequent waking	◯Yes ◯No
Epilepsy/Seizures	◯Yes ◯No	Stomach Ulcers	◯Yes ◯No
Diabetes	◯Yes ◯No	MS	◯Yes ◯No

HEALTH HISTORY

Does floss shred when you use it? ◯Yes ◯No
Does food pack or catch between your teeth? ◯Yes ◯No
Do you smoke or chew tobacco? ◯Yes ◯No
Do your gums bleed? ◯Yes ◯No
Does your breath concern you? ◯Yes ◯No
Are your teeth sensitive to? ☐Hot ☐Cold ☐Sweets ☐Biting Pressure
Does food contsantly get stuck between certain teeth? ◯Yes ◯No
Do you get frustrated because something always needs to treated or repaired when you visit the dentist? ◯Yes ◯No
Are you dissatisfied with your teeth in any way? ◯Yes ◯No
Do any of your fillings show when you smile? ◯Yes ◯No
If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth colored restoration instead? ◯Yes ◯No
Do your gums bleed when brushing? ◯Yes ◯No
Have you been instructed regarding proper home care? ◯Yes ◯No
Do you have an unpleasant taste or odor in your mouth? ◯Yes ◯No
Do you frequently snack between meals or sweets or chew gum? ◯Yes ◯No
How often do you brush your teeth? _____
How often do you use floss? _____
Do you want to learn to control dental disease and retain your teeth? ◯Yes ◯No
Has the fear of discomfort kept you from regular dental visits? ◯Yes ◯No
Are you deeply concerned about the finances required to return your mouth to excellent dental health? ◯Yes ◯No

Do you have or have you had any disease, condition, or problem not listed?_____
_____

Have you ever had any cosmetic procedure? ◯Yes ◯No
If so, for what?_____

Women: Are you: Pregnant?_____ Nursing?_____ Taking birth control pills?_____

I understand that I am responsible for all costs of dental treatment. I hereby authorize Royal Oak Dental Group to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental and medical histories and other information about my dental treatment to third party payors and/or other health professionals.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication. We ask that you please turn off your cell phone before treatment.

Signature_____ Date_____

Parent's Signature if Minor_____

LIST of MEDICATIONS	**DOSAGE**	**HOW OFTEN TAKEN**

Your Name_____

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Here are some things we are going to be talking about at your first visit. These are issues you have probably never thought of. Please check what best expresses how you feel about the following questions.

- Are you having any areas of concern?_____
- Tell us, in your opinion, what you think the present state of the health of your mouth is?_____
- What do you already know about our office and what are your expectations?
  _____
- How healthy do you want us to get your mouth?
  ◯ Don't really care ◯ Average ◯ The best it can be

- Should you need treatment, at what point should we address it?
  - ◯ When my tooth hurts or breaks
  - ◯ When something is worsening
  - ◯ When something isn't ideal

- What quality of dentistry do you want us to recommend?
  ◯ Just patch it ◯ Average ◯ Ideal/the best

- We have the ability to look at your mouth from 3 different perspectives. What combination of these would you like us to use for you?
  ☐ As a **general** dentist ☐ As a **cosmetic** dentist ☐ As a **functional** dentist

- How do you feel about the appearance of your face and smile?_____
  _____

- What would it take for you to trust us to be your dentist?_____
  _____

- Tell us about your **good** dental experience…_____
  And the **bad** ones…_____

- Has fear ever been an issue for you in a dental office?_____

- What caused you to leave your last dental office?_____

- Has time ever been a factor in getting your dental work done?_____

- Has the cost of dental treatment been a concern for you?_____
  What can we do to help you with this?_____

Is there any additional information you would like us to know?

ROYAL OAK DENTAL GROUP

Patient's Name_____ Date_____

Musculoskeletal Screening Questionnaire

One or more of the following symptoms may be indicative of musculoskeletal dysfunction of the head and neck. If you have any of the following symptoms, please indicate by checking the appropriate areas. (L = Left, R = Right)

a. Pain in the jaw joint ☐L ☐R
b. Pain in ear ☐L ☐R
c. Pain around eyes ☐L ☐R
d. Pain in lower jaw ☐L ☐R
e. Pain in upper jaw ☐L ☐R
f. Pain in neck ☐L ☐R
g. Pain in shoulder ☐L ☐R
h. Pain in forehead ☐L ☐R
i. Pain in temples ☐L ☐R
j. Pain in facial muscles ☐L ☐R
k. Facial muscle twitch ☐L ☐R
l. Subjective hearing loss ☐L ☐R
m. Clicking or popping ☐L ☐R
sound in joint (circle which sounds most descriptive
n. Grating sound in joint ☐L ☐R
o. Dizziness (vertigo) ◯Yes ◯No
p. Ringing sound in ears ☐L ☐R
q. Fullness, pressure or ☐L ☐R
blockage in the ear

r. Headache ◯Yes ◯No
Tension headaches ◯Yes ◯No
Migraines ◯Yes ◯No
How often? _____
Top of head ◯Yes ◯No
Forehead ◯Yes ◯No
Back of head ◯Yes ◯No
Temples ◯Yes ◯No
Behind eyes ◯Yes ◯No
s. Partial inability to open ◯Yes ◯No
mouth If yes, (1) Constant ☐
(2) Sporadic ☐
t. Difficulty chewing ◯Yes ◯No
u. Difficulty swallowing ◯Yes ◯No
v. Pain in tongue ◯Yes ◯No
w. Difficulty breathing ◯Yes ◯No
through nose
x. Loud snoring ◯Yes ◯No
y. Constantly tired ◯Yes ◯No
z. Mouth breather at night ◯Yes ◯No

aa. Awaken with a dry mouth ◯Yes ◯No
If yes, 1) Frequently ☐
2) Rarely ☐
3) Never ☐

bb. Loose teeth (specify)_____

Occlusal Habits:

☐ Clenching ☐ AM ☐ PM
☐ Grinding on teeth ☐ AM ☐ PM
☐ Teeth hit in front first
☐ Cheek biting
☐ Gum chewing
☐ Pipe smoking
☐ Pencil biting
☐ Nail biting
☐ Other:_____

Postural Habits:

☐ Phone cradling
☐ Leans chin on hand
☐ TV watching
☐ Heavy lifting
☐ Shoulder bag
☐ Other:_____

1. What are your chief complaints? List from most to least important.
   a._____
   b._____
   c._____
   Other symptoms (please write in.)_____
   _____
   _____
2. Do symptoms affect one or both joints? Right ☐ Left ☐ Both ☐
3. How many years, months, weeks or days have you been bothered by this problem?
   a.____years b.____months c.____weeks d.____days
4. Have you had any injury to the jaw or face? ◯ Yes No ◯
5. Do you have arthritis? ◯ Yes No ◯
6. Have you ever had cervical traction? ◯ Yes No ◯
7. Have you ever worn a neck brace? ◯ Yes No ◯
8. Have you had any other treatment for this problem? ◯ Yes No ◯
   (If yes, explain-medicine, dental appliances such as a splint, orthotic, or night guard) _____
9. Have you had your teeth straightened (orthodontia)? ◯ Yes No ◯
10. Have you had teeth removed for orthodontia? ◯ Yes No ◯
11. Have you had your wisdom teeth removed? ◯ Yes No ◯
12. Have you ever had general anesthesia? ◯ Yes No ◯
13. Did you have allergies as a child? ◯ Yes No ◯
14. Have you had your bite adjusted by your dentist? ◯ Yes No ◯
    (equilibration) If yes, explain when._____
15. Do you attribute the symptoms to any one incident? ◯ Yes No ◯
    If yes, explain_____
    _____
16. Have you had cortisone injected into your joint? ◯ Yes No ◯
    If yes, when?_____ How many injections?_____
17. Do you chew gum? ◯ Yes No ◯

18. Please list chronologically, names and types of doctors and their locations, whom You have seen in the past for this or related problems. Write on back of this sheet if necessary.

Date visited	Name	Type	Address

19. In your opinion, what initiated your present condition (chief complaint)?

_____
_____
_____
_____
_____

20. What aspect of your condition concerns you most?

_____
_____
_____

21. Please write in any other pertinent information that has not been covered previously? Write on the back of this sheet if necessary.

_____
_____
_____

ROYAL OAK DENTAL GROUP

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we would be pleased to assist you in receiving your maximum allowable benefits.

Payment for services is due at the time services are rendered unless arrangements have been approved in advance. We will be pleased to assist you in processing your insurance claim for your reimbursement. Any remaining balance 30 (thirty) days after we have filed a claim for you becomes your responsibility and is due and payable. If you have secondary insurance we will be happy to file these claims to be reimbursed by your secondary insurance company. A service charge of 18% per annum accrues on any portion of a balance remaining over 90 (ninety) days.

Financial responsibility for patients that are minors lies with the parent who accompanies the child to the appointment. We will happily provide a statement of services and payment receipt to you upon request. Minors should be accompanied by a parent to answer any questions which regard treatment or patient care.

Our staff will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however;

1. Your insurance is a contract between you, your employer, and your insurance company.
2. The insurance coverage you will receive depends upon the quality of the plan purchased by the employer. Plans vary greatly and insurance companies do not give us the exact reimbursement amounts. Please contact your insurance company if you need an exact reimbursement amount.
3. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

For your convenience you may pay by cash, check Visa, Mastercard, Discover, or American Express. Financing is available with approved credit. Please ask us for details.

When canceling an appointment a 24 hour notice is required. If such a notice is not given, or you fail to show up for your appointment, a $76 fee (the minimum cost of your appointment) will be charged to your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to assist you.

I have read the above Financial Policy and agree to all payment terms. I further authorize the office to release any information concerning my case to my insurance company.

_____ _____

Patient/ Responsible Party Signature Date

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE READ IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (AHIPPA@) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by an alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 14, 2004 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have a right to file a complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures for our office. We will not retaliate against you for the complaint.

For more information about HIPPA Or to file a complaint:
The U.S. Department of Health and Human Services Office of Civil Rights
PA 200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257 or Toll Free: 1-877-696-6775

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____E-mail:_____

Patient # :_____Social Security # :_____

SECTION B: 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Craig Brooks

Telephone: 919-986-6211 Fax: 919-914-6370

E-mail: chapelhill@ royaloakdentalgroup.com

Address: 1525 East Franklin Street, Suite 2, Chapel Hill, NC 27514

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. 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.

SIGNATURE

I, _____, have had 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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____