Jaclynn Spencer D.D.S.
Brighton Smiles, PC
Family Dentistry

Today's Date: ___________

Patient Information

Name (Last, First, Middle): ____ Title: ____________

Preferred Name: ____Sex: _____________

SS NO.: ______-______-______ DOB: ______-______-______ Age: ______ Marital S / M / D / W

Home Address: ____

City Zip

Home Phone: (_____)____________Work Phone: (_____)____________Cell: (_____)____________

Occupation:____ Employer:___________________________

E-Mail: ____ Drivers License No.: __________________

Emergency Contact: _________________________________ Phone No.: (_______)__________________

Name of Physician:__________________________________ Phone No.: (_______)__________________

Pharmacy: ____ Phone No.: (_______)__________________

If under 18

Mother ____ DOB: ______-______-______

Father ____ DOB: ______-______-______

If you are completing this form for another person, what is your relationship to this person?:_______________

Whom may we thank for referring you to our office? ____

Acknowledgment of receipt of Notice of Privacy Practices.

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

____ ________________________

Signature of Patient / Legal Guardian Date

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Medical Information

Name ____

Today's Blood Pressure ________________

Are you in good health? ____

Have you had a serious illness, operation, or been hospitalized in the past? What? ____________________

Have you had an orthopedic total joint replacement?_______Date _________ Any complications?_________

Has a physician or previous dentist recommended antibiotics prior to dental treatment? ________________

Are you taking Fosamax, Actonel, or Boniva, for osteoporosis, or Paget's DX?________________________

Were you treated or are you presently being treated with intravenous bisphosphonates (such as Aredia or Zometa) for bone pain, hypercalcemia, Paget's, Multiple Myeloma, Metastatic cancer? Date ____________

Do you have a history of: Artificial heart valve, Previous infective endocarditis, Damaged valves in a heart transplant, Unrepaired cyanotic CHD, Repaired CHD completely in the last 6 months, Repaired CHD with residual defects? ____

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of heart disease.

Y N Conditions

- ☐ ☐ Anemia
- ☐ ☐ Angina
- ☐ ☐ Abnormal Bleeding
- ☐ ☐ Arthritis
- ☐ ☐ Aids/HIV
- ☐ ☐ Autoimmune Disease
- ☐ ☐ Artificial Bones/Joints
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Cancer
- ☐ ☐ Chemotherapy
- ☐ ☐ Diabetes
- ☐ ☐ Epilepsy
- ☐ ☐ Eating Disorder
- ☐ ☐ COPD
- ☐ ☐ Glaucoma

Y N Conditions

- ☐ ☐ GERD/Heartburn
- ☐ ☐ Heart Attack
- ☐ ☐ Heart Murmur
- ☐ ☐ Heart Problems/Surgery
- ☐ ☐ Hepatitis
- ☐ ☐ High Blood Pressure
- ☐ ☐ High Cholesterol
- ☐ ☐ Kidney Problems
- ☐ ☐ Liver Problems
- ☐ ☐ Mental Health Disorders
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Pacemaker
- ☐ ☐ Pregnant
- ☐ ☐ Radiation Treatment
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Neurological Disorder
- ☐ ☐ Osteoporosis

Y N Conditions

- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Respiratory Problems
- ☐ ☐ Seasonal Allergies
- ☐ ☐ Sinus Problems
- ☐ ☐ Seizures
- ☐ ☐ Stroke
- ☐ ☐ Systemic Lupus Erythematosus
- ☐ ☐ Tobacco Habit
- ☐ ☐ Thyroid Problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers

Do you have any disease, condition, or problem not listed above that you think we should know about?
If so, please list all ____________
____
____

Allergies

- ☐ Local Anesthetic
- ☐ Latex
- ☐ Sedatives
- ☐ Other Food
- ☐ Sulfa Drugs
- ☐ Metals
- ☐ Codine or Other Narcotics
- ☐ Milk
- ☐ Other Antibiotics
- ☐ Aspirin
- ☐ Iodine
- ☐ Penicillin
- ☐ Other: ________________

Are you taking any prescriptions or over the counter medications?
If so, please list all: ____

Both Dr. and patient are encouraged to discuss any and all relevant patient health concerns prior to treatment. I understand the importance of a truthful health history and I certify that the information given on this form is accurate. I will not hold my dentist or her team responsible for any action they take or do not take because of errors or omissions.

Signature ____ **Date** ______________

The above information is accurate and complete to the best of my knowledge.

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Today's Date: ____________

Dental Health Information

Please state your reason for seeking dental care at this time: ____________

Are you currently experiencing dental pain or discomfort? ____________

Where? ____________ How long? ____________

How long since your last dental visit? ____________

How long since your last dental cleaning? ____________

On a scale of 1-10, how healthy do you feel your mouth is? 1 2 3 4 5 6 7 8 9 10

Are you apprehensive about dental treatment? ____________

Do your gums bleed? ____________

Are your teeth sensitive to hot, cold, sweets? ____________

Are you happy with your smile?____________

Do you frequently have a dry mouth? ____________

Do you have sores or ulcers in your mouth?____________

Do you have ear aches, neck pains, or headaches?____________

Do you have clicking, popping or discomfort in your jaw? ____________

Do you grind or clench your teeth? ____________

Have you had orthodontic treatment? ____________

Have you had any periodontal (gum) treatments? ____________

Do you have a history of mouth breathing, snoring or sleep apnea? ____________

Have you had any problems or complications associated with previous dental treatment? ____________

Additional Child's History:

trauma	*mouth sores*	*mouth breather*	*chapped lip,*
speech problems	*curious tongue*	*snoring*	*bed wetting*
toss & turn at night	*wakes frequently at night*	*frequent nightmares*	*grinding*
dark circles under eyes	*headaches*	*earaches*	*frequent sore throat*
pacifier	*thumb sucker*	*allergies*	*attention problems*

____

Signature of Patient / Legal Guardian

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Name: ________________
Today's Date: ____________

Sleep Disordered Breathing Questionnaire

Do you experience any of these? (check all that apply)

_____ Difficulty breathing through your nose
_____ Nasal congestion on one side of your nose or the other
_____ Congestion that changes from one side to the other
_____ Sleep Apnea
_____ Frequent sinus infections
_____ Difficulty sleeping due to snoring
_____ Decreased sense of smell
_____ Use of steroid nasal spray

Section Score: ____________

Nights per week snoring and how loud?

_____ 2 or less (0 pts)
_____ 3 - 4 (2 pts)
_____ 5 or more (5 pts)
_____ Slightly louder than breathing (0 pts)
_____ As loud as talking (2 pts)
_____ Heard through closed doors or walls (5 pts)

Section Score: ____________

Witnessed Apnea or Startled Awakening or Gasping?

_____ Never (0 pts) _____ Occasionally (10 pts) _____ Frequently (15 pts)

Section Score: ____________

Neck or Collar Size:

Male
_____ Less than 17 in. (0 pts)
_____ 17 in. or greater (15 pts)

Female
_____ Less than 16 in. (0 pts)
_____ 16 in. or greater (15 pts)

Section Score: ____________

Sleepiness: How likely are you to doze off?

0 - Never 1 - Slight Chance 2 - Moderate Chance 3 - High Chance

_____ Sitting and reading
_____ Sitting, inactive in a public place (e.g. theatre or meeting)
_____ As a passenger in a car for an hour without a break
_____ Lying down to rest in the afternoon when able to do so
_____ In a car, while stopped for a few minutes in traffic

Section Score: ____________

Other:

_____ High Blood Pressure Treated (5 pts)
_____ 50 years old or more (1 pt)
_____ Female (pre-menopausal) (0 pts)
_____ Female (post-menopausal) (5 pts)
_____ Male (5 pts)

Section Score: ____________

TOTAL SCORE: ____________

0 - 17 pts (Low Suspicion of OSA)	= Sleep Study not Recommended
18 - 34 pts (Moderate Suspicion of OSA)	= Nocturnal pulse ox Recommended
35 - 51 pts (Moderate to High Suspicion of OSA)	= Laboratory Sleep Study Recommended
52 - 65 pts (High Suspicion of OSA)	= Laboratory Sleep Study Recommended

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Today's Date: ___________

PATIENT ACCOUNT INFORMATION

Name: ____

Primary Dental Insurance: ____

Policy Owner's Name: __________________________ Relation to Patient: ______________________

Policy Owner's Address ____

Policy Owner's Phone No.: (______)_______________

SS NO.: ________-________-________ DOB: ________-________-___________

Policy Owner's Employer: ____

Insurance Company's Name: __________________________ Group Plan No.: ______________________

Insurance Phone No.:(______)____________ E-Mail Address ______________________________

Insurance Billing Address: ____

****We will bill your insurance as a benefit to you. Co-payments and percentages will be collected at the time of service. It must be understood that dental insurance is a relationship between you, the insurance company and your employer. We will always recommend the treatment that is best for our patient. This is not always what your insurance company is willing to pay for, nor does having dental insurance guarantee full coverage of all procedures. You, the patient are ultimately responsible for any charges not paid by the insurance company. Accounts over 90 days will be subject to a finance charge. Accounts extended beyond 120 days will be sent to collections. We are here to make you feel comfortable and hopefully all your questions have been answered to the best of our ability.**

____ ______________________________

Signature of patient or guardian Date

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Notice of Privacy Practices

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996. (HIPAA) I understand that by signing this consent I authorize Dr. Jaclynn Spencer's office to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (my insurance company)
- The day-to-day healthcare operations of Dr. Spencer's practice

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Dr. Jaclynn Spencer's office will reserve the right to change the terms of this notice from time to time and that I may contact the office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used to carry out treatment, payment and health operations; however the office is not required to agree to these requested restrictions. If you agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time.

______________________________ ______________________
Signature of patient Date

______________________________ ______________________
Signature of patient or guardian Relationship to patient

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Office and Financial Policy

Thank you for choosing Brighton Smiles for your oral health needs. My team and I are committed to provide you with the best possible care. We will be available to discuss our professional fees with you at any time. Your clear understanding of our office and financial policy is important to our professional relationship. Please ask us if you have any questions about our fees, financial policy or your responsibilities.

PAYMENT POLICY: Payment is due at the time services are rendered. For your convenience we accept cash, check, MasterCard and Visa. In special circumstances, extended payment arrangements may be established at your consultation visit. All payment arrangements must be made prior to beginning any treatment. In the event that your account incurs a balance, you are responsible for making timely payments. All balances must be paid in ninety (90) days.

In the event of default, the outstanding balance shall accrue interest at the rate of 18% per annum for the date of default until paid in full. If the outstanding balance is referred to a collection agency, I/we agree to pay, in addition to interest at the rate of 18% per annum, a reasonable collection agency fee and all other costs, including but nit limited to attorney fees and court costs. If such action occurs, it is understood that the patient, guardian and family will be unable to continue with the doctor or her auxiliary staff.

INSURANCE: Insurance is a contract between you and your insurance company. Our office will file your claim and attempt to collect payment on your behalf. It is your responsibility to know and understand your dental insurance benefits. You will be expected to pay all estimated patient payments at the time services are rendered.
Procedures not covered by your plan and claims not paid within sixty (60) days are your responsibility. Your provider determines the diagnosis as well as the appropriate designation of the type of visit. Some services may not be covered or paid for by your particular insurance benefits, or they may go towards your deductible. Coding for your service will be determined by your dental provider based on the actual services performed and will not be changed to satisfy any insurance limitations. Please contact your insurance plan provider or human resource department for benefit details.

MISSED / CANCELED APPOINTMENTS: Our office policy is to charge for appointments missed or canceled without 48 hours' notice. The charge will range from $40 up to the rate of your scheduled appointment. Please help us serve you and all of our patients better by keeping your reserved appointments.

LATE ARRIVALS: If you are 10 minutes or more late to the scheduled appointment time, your appointment may be rescheduled.

CONSENT: The undersigned hereby authorizes Dr. Spencer to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis, perform any and all treatments needed, including but not limited to medications, therapy or treatment of the oral cavity. I understand there are risks involved with each and every dental procedure including the administering of anesthetic(s). It is my personal responsibility to request information about treatment so I can make informed decisions regarding my health and dental treatment. Dr. Spencer may choose and employ such assistance as she deems fit. Dr. Spencer may delegate certain tasks to be performed which are legal and ethical by dental assistants and/or hygienists under Colorado dental practice law 12-35-128. Such tasks can be performed with direct or indirect supervision. I understand and consent to the above information regarding treatment, payments, insurance, missed/canceled appointments and late arrivals.

________________________________ ____________________

Signature of patient or guardian Date