Green Hills Dentistry
1150 Glenlivet Drive, Suite C38 , Allentown, PA 18106 Phone: 610.395.0980, FAX: 484.223.1933

PATIENT INFORMATION

Patient Name: _____
First Middle Initial Last

Salutation: Mr. Mrs. Ms. Dr. Preferred Name: _____ Whom may we thank for referring you? _____

Patient Address: _____ City: _____State: _____ Zip: _____

Phone Number: _____Work: _____ Ext: _____ Cell: _____

Email Address if you wish to receive correspondences via email: _____

Birthdate: _____ Sex: Male Female Marital Status: ___ Married ___ Not Married

Emergency Contact Name: _____ Phone #: _____

Preferred Pharmacy: _____ Location: _____

RESPONSIBLE PARTY

Person responsible for patient: _____ Relation to Patient: _____

Address: _____ City: _____State: _____ Zip: _____

Phone Number: _____Work: _____ Ext: _____ Cell: _____

Email Address if you wish to receive correspondences via email: _____

Birthdate: _____ Sex: Male Female Marital Status: ___ Married ___ Not Married

Currently a Patient in our Office: Yes No

DENTAL INSURANCE INFORMATION

Policy Holder Name: _____ Relation to Patient: _____

Address: _____ City: _____State: _____ Zip: _____

Birthdate: _____ SS#: _____ Insurance ID #_____

Employer: _____

Insurance Company Name: _____ Group Number: _____

Insurance Company Address: _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder Name: _____ Relation to Patient: _____

Address: _____ City: _____State: _____ Zip: _____

Birthdate: _____ SS#: _____ Insurance ID #_____

Employer: _____

Insurance Company Name: _____ Group Number: _____

Insurance Company Address: _____

GREEN HILLS DENTISTRY
FAMILY ▪ COSMETIC ▪ SLEEP SOLUTIONS

1150 Glenlivet Drive, Suite C38, Allentown, PA 18106 Phone: 610.395.0980 Fax: 484.223.1933 www.ghdentistry.com

Questionnaire For Snoring/Sleep Apnea

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not 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:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation:

_____ Sitting and reading

_____ Watching TV

_____ Sitting, inactive in a public place (e.g. movie theater or meeting)

_____ As a passenger in a car for an hour without a break

_____ Lying down to rest in the afternoon when circumstances permit

_____ Sitting and talking to someone

_____ Sitting quietly after lunch without alcohol

_____ In the car, while stopped for a few minutes in traffic

_____ **Total Score**

Behavior During Sleep

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

0 = never during a usual night

1 = less than once a week

2 = once to about half the nights/week

3= half the nights to almost always

4= almost always or every night

?= don't know or haven't been told

_____ Usual number hours of sleep/night

_____ Number of times you rise to use the toilet

During your usual sleep, you have noticed or have been told you do the following:

_____ Snore loudly

_____ Stop breathing

_____ Choke, struggle for breath

_____ Toss and turn frequently

_____ Wake up with a headache

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Dental Questionnaire

Reasons for this Initial Visit

1. What is your chief reason for making this appointment? _____
2. Who may we thank for referring you? _____
3. What specific things would you like us to pay special attention to? _____

History of Dental Care

1. When was your last visit to the dentist? _____
2. What was the reason for that visit? _____
3. Have you ever had a full series of 18 dental x-rays? Yes/no
   When _____
4. Have you ever been diagnosed with gum disease? Yes/no
5. Do your gums bleed when you brush or floss? Yes/no
6. Are you missing any teeth? Yes/no
   If so, have they been replaced? Yes/no
7. Have you ever had:
   - Gum surgery Yes/no
   - Root canal therapy Yes/no
   - Crown (caps) or bridge work Yes/no
   - Orthodontics Yes/no
   - Dental implants Yes/no
   - Full or partial removable dentures Yes/no

   Comments: _____

Screening for Jaw and Bite Problems

1. Do you have frequent headaches? Yes/no
   When (morning, evening, no pattern…) _____
   How often _____
2. Does your jaw click or get locked when you open or close? Yes/no
3. Do you have pain or tenderness in your jaw joint? Yes/no
4. Do you take pain medications including Aspirin or Ibuprofen? Yes/no
   How much _____
   How often _____
5. Do you clench or grind your teeth or ever been told you do? Yes/no
6. Have you noticed any of the following:
   - Tooth wear Yes/no
   - Gum recession Yes/no
   - Loose teeth Yes/no
7. Do you have a history of fractured teeth and/or fillings Yes/no
8. Are your teeth sensitive to cold, heat or sweets? Yes/no
9. Have you ever been diagnosed with “TMJ” problems? Yes/no
10. Do you snore? Yes/no
11. Do you tire easily? Yes/no
12. Have you ever been diagnosed with Sleep Apnea? Yes/no
13. Have you ever been prescribed a CPAP machine? Yes/no

Esthetic Concerns

1. Are you happy with the way your teeth look? Yes/no
2. Do you like your smile? Yes/no
3. Would you like your teeth to be whiter? Yes/no
4. What would you change about your smile if could? _____

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Affidavit for Intolerance or Non Compliance to CPAP

I, _____, have attempted to use CPAP (Continuous Positive Air Pressure) to manage my sleep related breathing disorder (OSA-Obstructive Sleep Apnea) and find it intolerable to use on a regular basis for the following reason(s):

- Mask Leaks
- An Inability to get the mask to fit properly
- Discomfort caused by the straps and headgear
- Disturbed or interrupted sleep caused by the presence of the device
- Noise from the device disturbing sleep or bed partner's sleep
- CPAP restricted movements during sleep
- CPAP does not seem to be effective
- Pressure on the upper lip causes tooth related problems
- Latex allergy
- Claustrophobic associations
- An unconscious need to remove the CPAP apparatus at night
- Other _____

Because of my intolerance / inability to use the CPAP, I wish to have my OSA treated by Oral Appliance Therapy utilizing a custom fitted Mandibular Advancement Device

Signature _____ Date ____/_____/_____

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Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
- ☐ Pregnant/Trying to get pregnant?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Osteoporosis	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Parathyroid Disease	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Psychiatric Care	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Radiation Treatments	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Renal Dialysis	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Rheumatic Fever	☐ Yellow Jaundice
		☐ Hypoglycemia	☐ Rheumatism	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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Policies and Procedures

Welcome to Green Hills Family & Cosmetic Dentistry! Our mission is to deliver world class dental care with a keen focus on patient service. We respect your trust in our ability to help you protect your dental health, and improve your smile. We are confident that you will feel comfortable with our caring professional staff, and state of the art facility. What follows is a brief summary of our practice policies and procedures. If you have any questions or need further clarification, we will be happy to accommodate you. Thank you again for letting us earn your trust. We work hard to exceed your expectations.

_____ Initials

Appointments

We see patients by appointment only, and are pleased to offer extended office hours. If you must change an appointment, please notify us more than **24 hours** in advance. This will allow us to offer that reserved time to another patient who needs treatment. Appointments that are missed without notice or canceled in less than 24 hours will incur a fee based on the total time of the scheduled appointment. The fee will be $40 for every hour that reserved for that appointment.

_____ Initials

Emergency Care

If you should have an emergency, please call the office as early in the day as possible so we may see you promptly. If the office is closed, we can be reached via our paging system on our voice mail.

_____ Initials

Financial Policy

Payment is due at the time of service. If you have dental insurance, we will submit an electronic claim to your carrier so that you can be reimbursed quickly and efficiently. If you prefer to pay for your treatment in installments, please ask about our interest-free financing programs. Our flexible payment options assure that you can afford to have the care you want.

Accounts unpaid after 30 days from the date of billing are subject to a finance charge of 1.5% per month on the balance due. If your account needs to be referred to collections, you will be responsible for the cost of collection, as well as any court costs and reasonable attorney's fees.

For your convenience, if the person responsible for the patient's account payments will not be present at the time of their appointments, we will be happy to keep a current credit card number on file.

_____ Initials

Acknowledgement of Receipt

I acknowledge that I viewed a copy of Greens Hills Family & Cosmetic Dentistry **NOTICE OF PRIVACY PRACTICES.**

Please let us know how you would like to be contacted (check all that apply)*:
*Our patients like our email and text appointment reminders!

☐ **Home Phone Number:** _____

☐ **Cell Phone Number:** _____

☐ **Email:** _____

☐ **Text:** _____

I have read and accept the Policies and Procedures of Green Hills Family & Cosmetic Dentistry as outlined above.

Signature: _____Date: ____ / ____ /_____

NOTICE OF PRIVACY PRACTICES

Green Hills Family & Cosmetic Dentistry, P.C., 1150 Glenlivet Drive, Suite C38 , Allentown, PA 18106
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

~ When a state or federal law mandates that certain health information be reported for a specific purpose;
~ For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
~ Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
~ Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
~ Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
~ Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
~ Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
~ Uses or disclosures for health related research;
~ Uses and disclosures to prevent a serious threat to health or safety;
~ Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
~ Disclosures of de-identified information;
~ Disclosures relating to worker's compensation programs;
~ Disclosures of a "limited data set" for research, public health, or health care operations;
~ Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
~ Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

(OVER)

(CONTINUED FROM FRONT)

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

~ Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

~ Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

~ Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Green Hills Family & Cosmetic Dentistry, P.C. Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____