Patient Information: Today's Date:_____

Last Name:_____First Name:_____Middle Name:_____

Preferred Name:_____ Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Social Security No:_____ Gender:_____ Married:_____

Address:_____

City:_____ State:_____ Zip:_____

E-mail Address:_____

Place of Employment:_____Work Phone:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

If you are completing this form for another person, what is your relationship to that person? Name:_____ Relationship:_____
If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

Sponsor/Parent/Guardian Information: Relationship to Patient:_____ Self:_____

Last Name:_____First Name:_____Middle Name:_____

Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Social Security No:_____ Date of Birth:_____ Employer:_____

Insurance Information:

Insurance Carrier:_____ ID Number:_____ Group Number:_____

Insurance Phone Number:_____ Insurance Address:_____

Name and Number of nearest relative not living with you:_____
How did you hear about us?_____

To the best of my knowledge, all of the answers regarding my personal and medical information are true and correct. If I ever have any changes in my health, or if any medicines change, I will inform my dentist at the next appointment.

Signature of Patient/Parent/Guardian:_____

Patient's Name:_____ Date:_____

Dental History:

Date of last dental visit:_____ Reason for today's visit:_____
Are you nervous about dental treatment?_____ Do you have any dental concerns?_____
Have you been diagnosed with gingivitis/periodontal disease?_____ Do your gums bleed, feel tender or irritated?_____
Are your teeth sensitive?_____ If yes, to what? Sweets:_____ Hot:_____ Cold:_____ Pressure:_____
Have you had orthodontics?_____Do you wear any type of occlusal guard or retainer?_____
Are you unhappy with the appearance of your teeth?_____
Has a physician or dentist recommended that you **pre-medicate** with an antibiotic prophylaxis before having dental work done?_____

Medication History: List all Medications you are currently taking below, including over-the-counter medicine, vitamins/supplements and herbs. Include information about how much and how often.

_____
_____
_____

Allergies: Please mark any of the following medical allergies you have.

_____ **None**	_____ Codeine	_____ Latex	_____ Penicillin
_____ Aspirin	_____ Other Narcotics	_____ Local anesthetics	_____ Other Antibiotics
_____ Barbiturates	_____ Iodine	_____ Sulfa Drugs	_____ Other:_____

Medical History: Please mark any of the following which you have had or have at present.

Heart Health	**Respiratory Health**	**Brain/Mental Health**	**Other**
_____ Heart Disease	_____ Asthma/COPD	_____ Anxiety	_____ Glaucoma
_____ Heart Murmur	_____ Bronchitis/Emphysema	_____ Depression	_____ Arthritis
_____ High Blood Pressure	_____ Sinus Trouble	_____ Seizures/Epilepsy	_____ Chronic Pain
_____ Pacemaker	_____ Tuberculosis	_____ Mental Health Disorders	_____ Diabetes
_____ Heart Attack	**Cancer**	_____ Neurological Disorders	_____ Hepatitis
_____ Stroke	_____ Chemotherapy	_____ PTSD	_____ Kidney Issues
_____ Heart Medications	_____ Radiation	_____ Other	_____ Malnutrition
_____ Other	Type:_____	**Periodontal Health**	_____ Osteoporosis
Blood Health	**Autoimmune Disease**	_____ Swollen gums	_____ Cold Sores
_____ Anemia	_____ AIDS/HIV	_____ Loose teeth	_____ STDs
_____ Hemophilia	_____ Lupus	_____ Bad breath	_____ Thyroid Issues
_____ Low Blood Pressure	_____ Other	_____ Dry mouth	_____ Hearing Issues
_____ Blood Thinners	**Digestive Health**	_____ Food catching between teeth	_____ Sight Issues
_____ Other	_____ Gastrointestinal Disease	_____ Family history of Gum Disease	_____ Dementia
_____ Immuno-compromised	_____ Gerd/Acid Reflux	_____ Calcium deficiency	_____ Alzheimer's
	_____ Stomach Ulcers	_____ Vitamin D deficiency	_____ Other

Are you currently being seen or treated by a physician?_____ If yes, for what condition?_____
Are you taking any **blood thinners**? _____ If yes, what medication are you taking?_____
Are you taking any medication to treat osteoporosis? _____ If yes, what medication are you taking?_____
Do you use any type of tobacco, nicotine, or vaping products?_____ Type?_____
Amount Per Day?_____ Number of Years?_____ When did you quit?_____
How many alcoholic beverages do you have per week?_____
Do you use controlled substances, including marijuana, for medicinal or recreational reasons?_____
What substance? _____ How often is your use? _____ Was it prescribed by a doctor? _____
Have you had any type of joint replacement surgery ? _____ Date of surgery? _____
Have you had artificial heart valve surgery?_____ Date of surgery?_____
For Women: Are you: _____ Pregnant _____ Nursing _____ Using contraceptives _____ Taking hormone replacements
Is there anything else we should know about your health?_____

Financial Policies and Information

PLEASE READ CAREFULLY

Our commitment is to provide the very best care to you, our patient. Your clear understanding of- and agreement to- our financial policies concerning your dental care is fundamental to our professional relationship with you. Should you have additional questions about our fees and financial policies, or about your responsibilities relating to your insurance coverage, please contact the Practice Manager.

PROFESSIONAL FEES: Our prices are representative of the usual and customary charges for our area. Our fees reflect the Provider's time dedicated to your care. That time includes the review of any prior records, diagnostic testing, authorizations and other insurance requirements as well as the coordination of your care with other physicians involved in your health care planning.

INSURANCE PAYMENTS: We participate in assignment of payment with specific insurance plans. **Your insurance coverage is a contract between you and your insurance plan.** It is your responsibility to verify and know your insurance benefit coverage including your out-of-pocket requirements. If your insurance plan is one with which we participate and if you have provided valid proof of insurance for that plan, we will submit your claim(s) as a courtesy to you, our patient.

PROOF OF INSURANCE: Before being seen by a Provider, you must complete the Patient Information Form; provide a driver's license or legal identification card; and, provide a current valid insurance card as proof of insurance. If the insurance information you provide is incorrect, you will be responsible for the balance of the claim.

PATIENT PAYMENTS/SELF-PAY BALANCES: **Your co-payments and deductibles, services not covered by your insurance plan, and, self- pay balances are due at the time of your appointment.** Your balances are due upon receipt of the statement unless you have made other arrangements prior to the service being rendered. You may pay by cash, check or credit card. We accept Visa, MasterCard, Discover and American Express. **After 90 days of non-payment, a late fee charge of $10.00 per month will be added to your account and your account may be turned over to a collection agency.**

APPOINTMENTS: Please understand that your appointment is time that has been reserved for your health care needs. If you need to cancel your office and/or procedure appointment, please call us 48- hours in advance. **If you fail to give the proper notice or fail to show up for a scheduled office appointment, you will be assessed a $50 No Show fee that will be due before your next office visit.**

NON-COVERED SERVICES: Some services you receive may be non-covered or may be considered not necessary by your insurer. You must pay for these services in full at the time of your visit. Insurance carriers will sometimes limit coverage of certain services based on the diagnosis or the frequency in which they are performed. In the event that your provider identifies the potential for denial of your claim for either of these reasons, you will be provided with the expected cost to you for the services prior to services being rendered. You will be able to elect to receive the services and be responsible for the cost or elect to decline the services.

COLLECTION AGENCIES: If it becomes necessary to place your account with a third-party collection agency due to non-payment, you may be discharged from our Practice. Should this occur, we will treat you on an emergency basis only for the next 30 days while you find alternative care.

BOUNCED CHECKS: A $50 charge will be applied for each check returned by your bank. If you have had more than one bounced check, your Provider may elect to not accept future checks from you.

YOUR SIGNATURE ON THIS PAGE CONSTITUTES AN AGREEMENT TO THIS POLICY.

I have read and agree to the above Financial Policies and Information. I hereby assign all dental benefits to which I am entitled through my insurance - governmental or private - to Mid Bay Dental. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is considered as valid as the original.

Name of Patient: _____ Date: _____

Signature of Patient/Parent/Guardian: _____

NOTICE OF PRIVACY PRCTICES SUMMARY (HIPPA)

This summary discloses how Healthcare information about you may be used by our office. A full notice of your privacy rights has been provided to you.

Treatment, Payment, Operations. We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

Uses and Disclosures for Appointment Reminders. We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office. If you request such communication be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

Authorization for Use and Disclosure. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Public Health, Research, Health and Safety, Government, Workers Compensation. We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

Rights. You have the right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

Complaints. You may contact our Office Manager at 850-897-4200 or the Department of Health and Humas Resources if you believe your rights have been violated. You will not be retaliated against for filing a complaint.

Organization Duties. We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restrictions on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above or permitted under law.

Questions. If you have any questions, please contact our Office Manager at 850-897-4200.

I acknowledge that I have received the full Privacy Notice.

Name of Patient:_____ Date:_____
Signature of Patient/Paretn/Guardian:_____

For Office Use Only:
_____ Patient refused to sign.
_____ Patient unable to sign.
_____ Other:_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

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

It is important that you circle a number (0 to 3) on each of the questions.

Situation	**Chance of dozing (0 to 3)**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place--for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you have had no alcohol)	0	1	2	3
In a car while stopped at traffic	0	1	2	3
			Total Score	

0 - 10 Normal

11-15 Mild to Moderate Sleep Disorder

16 - 24 Severe Sleep Disorders and a Referral is Recommended