## Jeffrey T. Morris, DDS 324 Tyson Ave., Paris, TN 38242 (731)642-7920

Patient Name	Male	Female_	_DOB_	Age
Address		City/State	e/Zip	
Home Phone	Work Phone		C	Tell Phone
Email	Prefer	red method o	of commun	nication
Social Security Number	Cur	rent Employ	er	
Marital Status	Spou	ise's Name_		
Whom may we thank for your r	eferral?			
Emergency Contact		Phon	e Number	
*******	******	*****	*****	*******
Responsible Party Name (if oth	er than self)		Da	te of Birth
A J J.,	(	Tity/State/7i	n	
Home Phone	Work Phone			SSN:
Current Employer				
********	******	******	*****	********
DENTAL INSURANCE INFO	RMATION			
Policy Holder Name	S	SN	I	Date of Birth
Employer	Insu	irance Co Na	ame	
Secondary Insurance				
Policy Holder Name		SSN		Date of Birth
Employer		urance Co N	ame	•
Office Policies and Authorizations I understand that payment is due for all services, Cash, Check, Visa, Mastercard, and CareCrerendered on my behalf or my dependents. I 30 days or older. Should my account become 24-hour notice for appointment cancellations that sometimes events arise that may not allow appointment, however after 3 missed appoint claims for payment for services rendered or "Signature on File". I further authorize payment and co-payments will be due at time of services records, and radiographs about my medical in necessary radiographs, study models, photos perform all recommended and agreed upon the fully aware that using anesthetic agents invo OSHA and permit the confidential discussion needle sticks and injuries resulting during my	dit are accepted forms of particular particular and accept that are delinquent, I will assume as. Appointments in this officers were used to cancel you to call to cancel you transfer our office reserves to necessary pre-authorization ment of any benefits to office. I understand I am responsibility, services rendered, and other diagnostic aids are treatment. I also authorize to I lives certain risks. I authorize to find my medical history. I converse to the care and my medical history. I converse to the care and my medical history. I converse to the care and my medical history. I converse to the care and my medical history. I converse to the care and my medical history. I converse to the care and my medical history. I converse to the care and my medical history. I converse to the care and my medical history. I converse to the care and my	ayment. I understa 1.5% MPR fina all additional coloce are valuable to rappointment. In the right not to rest to my insurance when a claim is possible for paymes, self-insurers, on the cessary treat as needed to make the use of anesthe ze this office and consent to HIV and	tand that I am nee charge is a lection costs a pyou, the patient that event we schedule further company on a filed. I undent regardless or their representment. I author a full diagnotics, sedatives, staff to use the differentiation blood in the patitis blood in	responsible for payment for all services automatically tabulated if my account is nd legal fees. Office policy requires a cent, and the service provider. We realize the will be happy to reschedule your the risits. I authorize this office to submit the my behalf and in my name listed as restand that insurance will be estimated of the coverage provided. I authorize that it is office and staff to take sis. I further authorize this office to and other medication (as needed) ame to Universal Precautions as outlined by cood testing and documentation for
I, THE UNDERSIGNED, HAVE RE	AD, UNDEKSTAND,	AND AUKEE		
Patient or Guardian Signature				Date

## MEDICAL HISTORY

PATIENT NAME		
Birth Date		
Although dental personnel primarily treat the area in and around yentire body. Health problems that you may have, or medication the important interrelationship with the dentistry you will receive. That questions.	nat you	may be taking, could have an
1. Are you under a physician's care now?	Yes	No
If yes, please explain:		
Have you ever been hospitalized or had a major operation?  If yes, please explain:	Yes	No
3. Have you ever had a serious head or neck injury?	Yes	No
If yes, please explain:		
4. Are you taking any medications, pills, or drugs?	Yes	No
If yes, please explain:		
5. Do you take, or have you taken, Phen-Fen or Redux?	Yes	No
6. Are you on a special diet?	Yes	No
7. Do you use tobacco?	Yes	No
8. Do you use controlled substances?	Yes	No
9. Do you require <b>Antibiotic Pre-medication</b> prior to dental work If yes, please explain the condition:	? Yes	No
Women:		
10. Are you Pregnant/Trying to get pregnant?	Yes	No
11. Taking oral contraceptives?	Yes	No
12. Nursing?	Yes	No
13. Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal La Other	tex	Local Anesthetics

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

Alzeheiners/Dementia Disease Yes No Heart Mateck/Failure Yes No Anaphylaxis Yes No Heart Murmur Yes No Atthritis/Gout Yes No Heart Trouble/Disease Yes No Atthritis/Gout Yes No Heypoglycemia Yes No Stathma/COPD Yes No Hypoglycemia Yes No Insight Heartbeat Yes No Blood Disease Yes No Insight Heartbeat Yes No Insight H	AIDS/HIV Positive	Yes,	No	Hay Fever	Vec	No
Anaphylaxis Anaphy	Alzheimer's/Dementia Disease					
Anemia Yes No Heart Pace Maker Yes No ArthritisCout Yes No Heart Trouble/Disease Yes No ArthritisCout Yes No Heart Trouble/Disease Yes No Arthritiscal Heart Valve Yas No Heart Trouble/Disease Yes No Arthritiscal Joint Yes No Heart Trouble/Disease Yes No Infractal Heart ArthritisCout Yes No Heart Trouble/Disease Yes No Infractal Hearthcat Yes No Stock Statisma/COPD Yes No Hives or Rash Yes No Stock Statisma/COPD Yes No Hives or Rash Yes No Stock Tregular Hearthcat Yes No Stock Tregular Hearthcat Yes No Infractal Hearthcat Yes No						· · · ·
Athritis/Gout	· · ·					· · · ·
Authficial Heart Valve	Arthritis/Gout	Yes	No			• • •
Antificial Joint Ves No Hives or Rash Yes No Asthma/CDP Yes No Hypoglycemia Yes No Blood Disease Yes No Irregular Heartbeat Yes No Blood Transfusion Yes No Liver Disease/Jaundice Yes No Cancer Yes No Liver Disease/Jaundice Yes No Cancer Yes No Low Blood Pressure Yes No Cancer Yes No Partifyroid Disease Yes No Cancer Yes No Renal Dialysis Yes No Disease Yes No Renal Disease Yes No Renal Disease Yes No Disease Yes No Renal Disease Yes No Shingles Yes No Single Protection Yes No Single Yes No Single Protection Yes No Single Protection Yes No Single Yes No Single Protection Yes No Single Protection Yes No Single Yes No Single Protection Yes No Single Protection Yes No Single Yes No Tonsillits Yes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Tonsillits Yes No Tons	Artificial Heart Valve	Yes	No			· · ·
AshmarCOPD Yes No Hypogycemia Yes No Infragular Heartheat Yes No Infragular Heartheat Yes No Infragular Heartheat Yes No Infragular Heartheat Yes No Illood Transfusion Yes No Liver Disease/Jaundice Yes No Lancer Yes No Liver Disease/Jaundice Yes No Chemotherapy Yes No Liver Disease/Jaundice Yes No Chemotherapy Yes No Lung Disease Yes No Chemotherapy Yes No Lung Disease Yes No Chemotherapy Yes No Mitrial Valve Prolapse Yes No Congenital Heart Disorder Yes No Pain in Jaw Joints Yes No Pain in Jaw Joints Yes No Pain In Jaw Joints Yes No Parathyriot Disease Yes No Pain In Jaw Joints Yes No Parathyriot Disease Yes No Pain In Jaw Joints Yes No Parathyriot Disease Yes No Pain In Jaw Joints Yes No Parathyriot Disease Yes No Pain In Jaw Joints Yes No Parathyriot Disease Yes N		Yes	No			· · ·
Allood Transfusion Allood Allood Pressure Allood	Asthma/COPD	Yes	No		Yes	No
ABP - (High, Low ) Yes No Liver Disease/Jaundice Yes No Cancer Yes No Low Blood Pressure Yes No Part In Jud Johnts Yes No Part In Jud Johnts Yes No Part In Jud Johnts Yes No Congenital Heart Disorder Yes No Part In Jud Johnts Yes No Constitution Yes No Part In Jud Johnts Yes No	Blood Disease	Yes	No		Yes	No
Cancer Yes No Lung Diseaser Yes No Chest Pains Yes No Chest Pains Yes No Chest Pains Cold ScresiFever Blisters Ves No Cold ScresiFever Blisters Ves No Congenital Heart Disorder Yes No Convulsions Yes No Consulsions Yes No Consulsions Yes No Radiation Treatments Yes No Cold ScresiFever Blisters Yes No Renal Dialysis Yes No Cold Scresifever Renal Dialysis Yes No Collegative Disorders Yes No Collegative Disorders Yes No Collegative Disorders Yes No Sinus Trouble Yes No Collegative Disorders Yes No Sinus Trouble Yes No Tonsillitis Yes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Comments:  The best of my knowledge, the questions on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  SNATURE OF PATIENT, PARENT, or GUARDIAN  SNATURE OF PATIENT, PARENT, or GUARDIAN	Blood Transfusion	Yes	No	Kidney Problems	Yes	No
Chemotherapy Yes No Lung Disease Yes No Chest Pains Yes No Mitral Valve Prolapse Yes No Chest Pains Yes No Mitral Valve Prolapse Yes No Chest Pains Yes No Pain in Jaw Joints Yes No Pain in Jaw Joints Yes No Pain in Jaw Joints Yes No Congenital Heart Disorder Yes No Parathyroid Disease Yes No Contisone Medicine Yes No Radiation Treatments Yes No Diseative Yes No Renal Dialysis Yes No Diseative Disorders Yes No Renal Dialysis Yes No Diseative Yes No Shingles Yes No Shingles Yes No Sinus Trouble Yes No Stomach/Intestinal Disease Yes No Stomach/Intestinal Disease Yes No Traquent Headaches Yes No Tonsillitis Yes No Tonsillitis Yes No Tonsillitis Yes No Tonsillitis Yes No Tuberculosis Yes No Tuberculosis Yes No Ulcers Yes No Ulcers Yes No Tuberculosis Yes No Ulcers Yes No Tuberculosis Yes No Ulcers Yes No Tuberculosis Yes No Ulcers Yes No No Have you ever had any serious illness not listed above? Yes No Tuberculosis Yes No Ulcers Yes No No Have you ever had any serious illness not listed above? Yes No Tuberculosis Yes No Ulcers Yes No No Have you ever had any serious illness not listed above? Yes No Tuberculosis Yes No Ulcers Yes No No Have you ever had any serious to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.	3P- (High, Low)	Yes	No	Liver Disease/Jaundice	Yes	No
Chest Pains Yes No Mirral Valve Prolapse Yes No Dold Sores/Fever Blisters Yes No Pain in Jaw Joints Yes No Dold Sores/Fever Blisters Yes No Parathyroid Disease Yes No Dornwisions Yes No Parathyroid Disease Yes No Dornwisions Yes No Psychiatric Care Yes No Disbetes Yes No Radiation Treatments Yes No Disbetes Yes No Renal Dialysis Yes No Disbetes Yes No Renal Dialysis Yes No Dispetes Yes No Renal Dialysis Yes No Digestive Disorders Yes No Shingles Yes No Sinus Trouble Yes No Sinus Trouble Yes No Stomach/Intestinal Disease Yes No Stomach/Intestinal Disease Yes No Trequent Cough Yes No Stomach/Intestinal Disease Yes No Trequent Cough Yes No Truberculosis Yes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Tuberculosis Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Yes No Have you ever had any serious on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.	Cancer				Yes	No
Congenital Heart Disorder  Sond Sores/Fever Blisters  Yes  No  Parin in Jaw Joints  Yes  No  Congenital Heart Disorder  Yes  No  Parathyroid Disease  Yes  No  Confisions  Yes  No  Parathyroid Disease  Yes  No  Contisions  Yes  No  Radiation Treatments  Yes  No  Digestive Disorders  Yes  No  Renal Dalysis  Yes  No  Rheumatic Fever  Yes  No  Digestive Disorders  Yes  No  Rheumatic Fever  Yes  No  Rheumatism  Yes  No  Shingles  Yes  No  Shingles  Yes  No  Sinus Trouble  Yes  No  Excessive Bleeding  Yes  No  Sinus Trouble  Yes  No	• •			Lung Disease	Yes	No
Congenital Heart Disorder Yes No Parathyroid Disease Yes No Convulsions Yes No Psychiatric Care Yes No Psychiatric Care Yes No Psychiatric Care Yes No Rendiation Treatments Yes No Rendiation Yes No Shingles Yes No Shingles Yes No Sinus Trouble Yes No Sinus Trouble Yes No Someochintestinal Disease Yes No Stomachintestinal Disease Yes No Stomachintestinal Disease Yes No Transilitis Yes No Stomachintestinal Disease Yes No Truberculosis Yes No Truberculosis Yes No Ulcers Yes No Ulcers Yes No Truberculosis Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Wes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Ulce						· · · =
Convulsions Yes No Psychiatric Care Yes No Cortisone Medicine Yes No Radiation Treatments Yes No Remai Dialysis Yes No Remai Dialysis Yes No Remai Dialysis Yes No Digestive Disorders Yes No Rheumatic Fever Yes No Digestive Disorders Yes No Rheumatic Fever Yes No Digestive Disorders Yes No Rheumatism Yes No Digestive Disorders Yes No Rheumatism Yes No Carlos Yes No Shingles Yes No Digestive Yes No Shingles Yes No Sinus Trouble Yes No Storach/Intestinal Disease Yes No Trequent Cough Yes No Storach Yes No Trouble Yes No Trequent Headaches Yes No Tonsillitis Yes No Trouble Yes No Tuberculosis Yes No Ulcers Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Tuberculosis Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Somments:						
Cortisone Medicine Yes No Renal Dialysis Yes No Renal Dialysis Yes No Diabetes Yes No Shingles Yes No Sinus Trouble Yes No Trequent Cough Yes No Trequent Cough Yes No Tonsillitis Yes No Tuberculosis Yes No Ulcers Yes No Ulcers  No  If yes, please explain:  Comments:  The best of my knowledge, the questions on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  SNATURE OF PATIENT, PARENT, or GUARDIAN  SINUS TREATMENT OF STATEMENT.	· -					
Diabetes Yes No Renal Dialysis Yes No Digestive Disorders Yes No Rheumatic Fever Yes No Digestive Disorders Yes No Rheumatic Fever Yes No Digestive Disorders Yes No Rheumatism Yes No Shingles Yes No Shingles Yes No Shingles Yes No Sinus Trouble Yes No Transilities Yes No Trequent Cough Yes No Trouble Yes No Ulcers Yes No Ulcers Yes No Trouble Yes No No Trouble Yes No Troub						· · · =
Digestive Disorders Yes No Rheumatic Fever Yes No Drug Addiction Yes No Rheumatism Yes No Epiplepsy/Seizures Yes No Shingles Yes No Excessive Bleeding Yes No Sinus Trouble Yes No Excessive Bleeding Yes No Sinus Trouble Yes No Excessive Thirst Yes No Spina Bifida Yes No Stomach/Intestinal Disease Yes No Frequent Cough Yes No Stroke Yes No Trouble Yes No Trouble Yes No Trouble Yes No Stroke Yes No Trouble Yes No Stroke Yes No Trouble Yes No Trouble Yes No Trouble Yes No Stroke Yes No Trouble Yes No Thyroid Disease Yes No Ulcers Yes No Have you ever had any serious illness not fisted above? Yes No Ulcers Yes No Have you ever had any serious illness not fisted above? Yes No Ulcers Yes No Have you ever had any serious illness not fisted above? Yes No Ulcers Yes No Ulcers Yes No Have you ever had any serious illness not fisted above? Yes No Ulcers Yes No Ulcers Yes No Have you ever had any serious illness not fisted above? Yes No Ulcers Yes						
Orug Addiction Yes No Rheumatism Yes No Pinlepsyl/Seizures Yes No Shingles Yes No Shingles Yes No Scessive Bleeding Yes No Sinus Trouble Yes No						
Epilepsy/Seizures Yes No Shingles Yes No Excessive Bleeding Yes No Sinus Trouble Yes No Excessive Bleeding Yes No Sinus Trouble Yes No Tonsillation Yes No Trequent Cough Yes No Tonsillation Yes No Tonsillation Yes No Thyroid Disease Yes No Tuberculosis Yes No Tuberculosis Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Ul	_	Yes	No	Rheumatic Fever	Yes	No
Excessive Bleeding Yes No Sinus Trouble Yes No Excessive Thirst Yes No Spina Blifida Yes No Sinus Trouble Yes No Scanding Spells/Dizziness Yes No Stomach/Intestinal Disease Yes No Trouble Yes No Stomach/Intestinal Disease Yes No Trouble Yes No Ulcers Ye	Orug Addiction	Yes	No	Rheumatism	Yes	No
Spina Bifida Yes No Spina Bifida Yes No Stomach/Intestinal Disease Yes No Stomach/Intestinal Disease Yes No Stomach/Intestinal Disease Yes No Trequent Cough Yes No Stroke Yes No Tonsillitis Yes No Tonsillitis Yes No Tonsillitis Yes No Tuberculosis Yes No Tuberculosis Yes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Tuberculosis Yes No Ulcers Yes No U	Epilepsy/Seizures	Yes	No	Shingles	Yes	No
Fainting Spells/Dizziness Yes No Stomach/Intestinal Disease Yes No Frequent Cough Yes No Stroke Yes No Stroke Yes No Frequent Headaches Yes No Tonsillitis Yes No Tuberculosis Yes No Tuberculosis Yes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No If yes, please explain:  Comments:  The best of my knowledge, the questions on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  SNATURE OF PATIENT, PARENT, or GUARDIAN	Excessive Bleeding	Yes	No	Sinus Trouble	Yes	No
Frequent Cough Yes No Stroke Yes No Frequent Headaches Yes No Tonsillitis Yes No Glaucoma Yes No Tonsillitis Yes No Thyroid Disease Yes No Tuberculosis Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Ulcers Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No Ulcers Yes No Ulce	Excessive Thirst	Yes	No	Spina Bifida	Yes	No
Tonsillitis Yes No Tonsillitis Yes No Talaucoma Tonsillitis Yes No Talaucoma Tonsillitis Yes No Tuberculosis Yes No Tuberculosis Yes No Ulcers Tuberculosis Yes No Ulcers Tonsillitis Yes No Tuberculosis Yes No Tuberculosis Yes No Tonsillitis Yes No Tuberculosis Yes No Tuberculosis Yes No Tonsillitis Yes No Tobsilities Yes No Tobsilitie	Fainting Spells/Dizziness	Yes	No	Stomach/Intestinal Disease	Yes	No
Thyroid Disease Yes No Tuberculosis Yes No Ulcers Yes No Ulcers Yes No Have you ever had any serious illness not listed above? Yes No  If yes, please explain:  Comments:  Thyroid Disease Yes No Ulcers Yes No  Have you ever had any serious illness not listed above? Yes No  If yes, please explain:  Comments:  Thyroid Disease Yes No  Ulcers Yes No  It is no  No  Comments:  Thyroid Disease Yes No  I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.	Frequent Cough	Yes	No	Stroke	Yes	No
Tuberculosis Yes No Ulcers Yes No  Have you ever had any serious illness not listed above? Yes No  If yes, please explain:  Comments:  the best of my knowledge, the questions on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  ENATURE OF PATIENT, PARENT, or GUARDIAN	Frequent Headaches	Yes	No	Tonsillitis	Yes	No
Ulcers Yes No  Have you ever had any serious illness not listed above? Yes No  If yes, please explain:  Comments:  the best of my knowledge, the questions on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  ENATURE OF PATIENT, PARENT, or GUARDIAN	Glaucoma	Yes	No	Thyroid Disease	Yes	No
Have you ever had any serious illness not listed above? Yes No  If yes, please explain:  Comments:  the best of my knowledge, the questions on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  BNATURE OF PATIENT, PARENT, or GUARDIAN				Tuberculosis	Yes	No
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  BNATURE OF PATIENT, PARENT, or GUARDIAN				Ulcers	Yes	No
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  BNATURE OF PATIENT, PARENT, or GUARDIAN	Have vou ever had anv se	erious	illness not listed above?	Yes No		
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.				,,,,		
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  SNATURE OF PATIENT, PARENT, or GUARDIAN	ii yes, piease explain:					
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orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  GNATURE OF PATIENT, PARENT, or GUARDIAN						
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orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  BNATURE OF PATIENT, PARENT, or GUARDIAN						
orrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any anges in medical status.  GNATURE OF PATIENT, PARENT, or GUARDIAN						
	GNATURE OF PATIENT,	PARE	ENT, or GUARDIAN			

## **Patient Acknowledgement of Privacy Practices**

I acknowledge 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 you 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 (e.g.: my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *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 you reserve the right to change the terms of this notice from time to time and that I may contact you 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 and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, 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. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this day of	, 20
Print Patient Name	
Relationship to Patient (if not self)	
Signature	

Jeffrey T. Morris, DDS 324 Tyson Ave. Paris, TN 38242

## **EPWORTH SLEEPINESS SCALE FORM**

Instructions: Be as truthful as possible. Print the form. Read the situation in the first column; select your response from the second column; enter that number in the third column. Total all of the entries in the third column and enter the total in the last box.

Situation	Responses	Score
	0 = would never doze	
Sitting and Reading	I'= slight chance of dozing	
	2 = moderate chance of dozing	
	3 = high chance of dozing	
	0 = would never doze	
Watching Television	1 = slight chance of dozing	
	2 = moderate chance of dozing	
3	3 = high chance of dozing	
Sitting inactive in a public place, for	0 = would never doze	
	1 = slight chance of dozing	
example, a theater or a meeting	2 = moderate chance of dozing	
1	3 = high chance of dozing	
As a passenger in a car for an hour	0 = would never doze	
	1 = slight chance of dozing	
without a break	2 = moderate chance of dozing	
j.	3 = high chance of dozing	
	0 = would never doze	
Lying down to rest in the afternoon	1 = slight chance of dozing	
Lying down to rest in the atternoon	2 = moderate chance of dozing	
	3 = high chance of dozing	
	0 = would never doze	
Sitting and talking to someone	1 = slight chance of dozing	
3	2 = moderate chance of dozing	
1	3 = high chance of dozing	
	0 = would never doze	
Sitting quietly after lunch when you've	1 = slight chance of dozing	
had no alcohol	2 = moderate chance of dozing	
1	3 = high chance of dozing	
	0 = would never doze	
In a car while stopped in traffic	1 = slight chance of dozing	
**	2 = moderate chance of dozing	
1 .	3 = high chance of dozing	
TOTAL SCOPE		
TOTAL SCORE		
<b>1</b>		