

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone _____ Cell _____ E-mail _____ Driver's license # _____ State: _____

SS #: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____ Hobbies: _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>
Sours?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you prefer to save your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you want complete dental care?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
How often do you brush?	_____	_____
How often do you floss?	_____	_____
Does your jaw make noise so that it bothers you or others?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your jaws frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	<input type="checkbox"/>
Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw symptoms or headaches upon awaking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find jaw pain or discomfort extremely frustrating or depressing?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a habitual gum chewer?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HEALTH HISTORY:
Do you have, or have you had, any of the following?

	Yes	No
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants)		
Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
Premedications required by physician _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Notes: _____

	Yes	No
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about?		
If so, please describe: _____		

Please List Any Recent/Current Medications:

Women Yes No

Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date:	_____	
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms?	_____	
_____	_____	

Notes: _____

Patient/Parent Signature: _____

Dentist Initial: _____ Date: _____

Welcome to Cascade Smiles

John M. Gallucci, DMD

Insurance Assignment of Benefits Record Release Authorization/Financial Responsibility

I, _____, hereby instruct and direct my dental insurance company, _____, to pay directly to Cascade Smiles for the dental expense benefits allowable and otherwise payable to me.

This payment will not exceed my indebtedness to Cascade Smiles and I agree to pay in a current manner, any balance of said professional service charges over and above this insurance payment.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collection of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of benefits.

Billing charge is 1.5% per month – annual percentage rate of 18% - on balances over 90 days. Minimum billing charge is \$2.

Signature of Policyholder: _____ Signature of Parent /Patient: _____ Date: _____

Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent Authorization and Release

You may refuse to sign this acknowledgement and authorization. In refusing, we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor/facilities in the future.

Please **print** your name: _____ Please **sign** your name: _____

If completing for someone else: Legal Representative: _____ Description of Authority: _____

How do you want to be addressed when summoned from the reception area:

☐ First Name ☐ Proper Surname ☐ Other _____

Please list any other parties who can have access to your health information:

Names: _____ Relationship: _____

I authorize contact from this office to **confirm my appointments, treatment & billing information** and to have **information about my health** conveyed via:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ **Any of the Above**



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 follow 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

Signed: _____ **Dated:** _____

John M. Gallucci, DMD

1017 Molalla Ave, Suite 1 • Oregon City, OR 97045-3772 • P:503.657.7770 • F:503.657.9832 • CascadeSmiles.com

Informed Consent for the Treatment of Sleep-Related Breathing Disorders

You have been diagnosed by your physician as requiring treatment for a sleep-related breathing disorder, such as snoring and/or obstructive sleep apnea (OSA). OSA may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels. This condition can increase a person's risk for excessive daytime sleepiness, driving and work-related accidents, high blood pressure, heart disease, stroke, diabetes, obesity, memory and learning problems, and depression.

What is Oral Appliance Therapy?

Oral appliance therapy for snoring and/or OSA attempts to assist breathing by keeping the tongue and jaw in a forward position during sleeping hours. OAT has effectively treated many patients. However, there are no guarantees that it will be effective for you. Every patient's case is different and there are many factors that influence the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience symptoms related to your sleep-related breathing disorder.

A post-adjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. This must be obtained from your physician.

Side-Effects and Complications of Oral Appliance Therapy

Published studies show that short-term side effects of oral appliance therapy may include excessive salivation, difficulty swallowing (with appliance in place), sore jaws or teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth, and short-term bite changes. There are also reports of dislodgement of ill-fitting dental restorations. Most of these side effects are minor and resolve quickly on their own or with minor adjustment of the appliance.

Long-term complications include bite changes that may be permanent resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once oral appliance therapy is discontinued. If not reversible, restorative treatment or orthodontic intervention may be required for which you will be responsible.

Follow-up visits with the provider of your oral appliance are mandatory to ensure proper fit and a healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further.

Alternative Treatments for Sleep-Related Breathing Disorders

Other accepted treatments for sleep-related breathing disorders include behavioral modification, Continuous Positive Airway Pressure (CPAP) and various surgeries. It is your decision to choose oral appliance therapy to treat your sleep-related breathing disorder and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to this provider's office. Failure to treat sleep-related breathing disorders may increase the likelihood of significant medical complications.

If you understand the explanation of the proposed treatment, have asked this provider any questions you may have about this form or treatment, please sign and date this form below. You will receive a copy.

Date of last dental visit _____

Is all dental treatment complete _____

Who is your treating Dentist _____

Signature: _____ Date: _____

Print Name: _____

© 2009, American Academy of Dental Sleep Medicine

John M. Gallucci, DMD
RECORD RELEASE TO PATIENT

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
TO INCLUDE SUPER CONFIDENTIAL PHI DIRECTLY TO THE PATIENT**

I, _____, hereby request a copy of my health records and authorize
John M. Gallucci, DMD, to use and disclose a copy of my health records to me.

I prefer my records be sent to me in the following format, but understand that by law, the records can be sent in any electronic format similar if the format I desire is not available. I know this Healthcare Facility will supply me these records within 30 days of this request and will contact me should there be any reason they need to extend this time frame. I understand, by law this Healthcare Facility and request an extension for more time but, can only request an extension, once for an additional 30 days. The format which I prefer to receive my electronic records in is:

- ☐ Email to dental office (email address): office@cascadesmiles.com
- ☐ Email a PDF copy to (email address): _____
- ☐ Fax a copy to (fax number): _____
- ☐ Send a hard copy to (address): _____
- ☐ I will pick up a copy on or after (date): _____

I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax or unencrypted email, the following types of **super-confidential information** as stated in the NOPP (initial where appropriate):

- ☐ HIV records (including HIV test results) and sexually transmissible diseases
- ☐ Alcohol and substance abuse diagnosis and treatment records
- ☐ Psychotherapy records
- ☐ Not Applicable

The undersigned does hereby release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

By Patient: _____ Date: _____
(Print name and sign)

or

By Patient's Representative _____ Date: _____
(Print name, sign, and describe authority below)

OFFICE USE ONLY

Describe what alternative communications were denied this _____ day of _____, 20_____

Describe what alternative communications were accepted this _____ day of _____, 20_____