

Kellye N. Rice, DMD
Cool Springs Laser Dentistry
Cosmetic and Family Dentistry with a Woman's Touch

CONFIDENTIAL DENTAL AND MEDICAL HISTORY

Personal History

Date: _____

Patient's Name: _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Home Address: _____
STREET CITY STATE ZIP

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Email Address: _____ Preferred Contact Method: Phone Email Text

Sex: M or F Date of Birth: _____ Social Security #: _____ Marital Status: S M W D

Employer: _____ Employer Address: _____

Spouse's Name: _____ Spouses Phone Number: (____) _____
(____) _____

In Case of Emergency Contact Phone Number Relationship

PATIENTS UNDER 18

Responsible Party: _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Relationship to Patient: _____ Date of Birth: _____ Social Security #: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

How did you hear about our office? Please check ALL that apply. Mailing Website Social Media Google

Radio Friend, Family or Coworker: _____ Other: _____
FIRST NAME LAST NAME

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

A copy of the Notice of Privacy Practices for Kellye N. Rice, D.M.D., P.L.L.C. has been made available to me. I am signing this form on behalf of myself and any of my dependents under the age of 18 who are, or will become, patients in this office.

PRINT NAME SIGNATURE DATE

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign Communications barriers prohibited obtaining the acknowledgment
 An emergency situation prevented us from obtaining acknowledgment Other (please specify) _____

Kellye N. Rice, DMD

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Reason for today's visit _____ Date of last dental visit: _____

Have you ever had any of the following: (check all boxes that apply)

DENTAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding of teeth | <input type="checkbox"/> Pipe, cigar, cigarette smoking |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Gum treatments | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Jaw popping | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Burning Tongue | <input type="checkbox"/> Jaw pop that went away | <input type="checkbox"/> Swelling in mouth |
| <input type="checkbox"/> Cheek, lip, fingernail biting | <input type="checkbox"/> Lip or mouth blisters | <input type="checkbox"/> Teeth straightened |
| <input type="checkbox"/> Chew on only one side of mouth | <input type="checkbox"/> Loose or broken fillings | <input type="checkbox"/> Tired jaws |
| <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Unpleasant taste |
| <input type="checkbox"/> Complications from Extractions | <input type="checkbox"/> Lump in mouth | <input type="checkbox"/> Unusual sounds while chewing |
| <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Major dental treatment (crowns) | <input type="checkbox"/> Wears CPAP |
| <input type="checkbox"/> Food impaction | <input type="checkbox"/> Many cavities | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Gag easily | <input type="checkbox"/> Mouth breathing | |

MEDICAL HISTORY

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous problems |
| <input type="checkbox"/> AIDS or other immunosuppressive disorder | <input type="checkbox"/> Ever taken Fen-Phen | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Recent weight loss |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> General allergies | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Special diet |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Hepatitis, jaundice, liver disease | <input type="checkbox"/> Swollen neck glands |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High or Low blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic diarrhea | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Lasik or eye surgery: Date: _____ | <input type="checkbox"/> Venereal disease |
| | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Other: _____ |

Has your physician advised you to **premedicate** with an antibiotic prior to having dental treatment? Yes No

Are you currently under the care of a physician? Yes No For what condition? _____

Name of Physician: _____ Last Visit: _____

List all medication you are currently taking _____

Have you ever had an allergy or adverse reaction to any medication? _____

PATIENTS UNDER 18

Weight _____ Height _____

FEMALE PATIENTS - Do you suspect you are pregnant? _____

Are you currently nursing? _____

The information on this form is accurate and complete to the best of my knowledge and is only for use in treatment. I will not hold Dr. Rice or members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient/parent: _____ Date: _____

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INSURANCE INFORMATION

Please be advised that we file insurance as a courtesy. Expenses incurred in our office are the responsibility of the patient, not the insurance company. **Should your claim be denied, payment in full is due immediately.** Furthermore, if your insurance company has not responded to our claim within 45 days from the date of service, the entire balance will be transferred to you, the patient, for immediate payment.

Patient's Relationship to Insurance Holder: Self Spouse Child Patient's Date of Birth: _____

Patient's Name: _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Insurance Holder's Name: _____ Date of Birth: _____
LAST FIRST

Insurance Holder's SS/ID #: _____ Plan Group #: _____

Insurance Holder's Employer: _____

Insurance Company: _____ Insurance Company Phone #: _____

If patient is a student *over* the age of 18 years, please complete:

Full time Part-time

School attending: _____

City, State: _____

It may be necessary for you to provide, direct to your insurance company, proof of student status in order to process any claims.

***Unfortunately, we are unable to accept assignment of benefits for a COBRA policy.
We will give you a receipt showing procedure codes, but you must pay for your treatment as rendered.***

Assignment of Benefits: I hereby authorize payment direct to Kellye N. Rice, DMD, PLLC for all dental services performed. I authorize the release of any dental information relating to my dental claim. I authorize the processing of my insurance claim via electronic transmission. I understand that my insurance coverage is based on a contract between the insurance carrier and my employer. Dr. Rice and her associates cannot be held responsible for changes in coverage, maximum limits and non-covered procedures.

Signature of patient/parent: _____ Date: _____

Kellye N. Rice, DMD
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PATIENT POLICY AGREEMENT

We are honored that you have chosen Kellye N. Rice, DMD, and PLLC for your dental care. Our priority is to help you keep a healthy mouth for life. This document describes our policy regarding payment for your treatment, as well as an overview of the payment plan options that are available. After you have read and understood each item, please initial where designated.

PAYMENT

Payment in full is due at time of service. If you have dental insurance, this includes your deductible, co-pay, non-covered procedures, and any amount over your maximum. We accept cash, check, and credit cards. We can also help you to set up payment plans through a financing company. **Initial:** _____

INSURANCE

Please be advised that we file DENTAL insurance as a courtesy and are preferred providers for a limited number of carriers. It is the responsibility of the patient to determine if we are a preferred provider for your policy. Expenses incurred at Kellye N. Rice, D.M.D., P.L.L.C. are the responsibility of the patient, not the insurance company. Should your claim be denied or payment of your claim is less than you expected, payment in full is due immediately. **Since Covid-19, we have seen an increase in the number of denied claims.** Furthermore, if your insurance company has not paid the estimated portion of your claim within 45 days from the date of service, the entire balance will be due by you, the patient. **Initial:** _____

BROKEN APPOINTMENTS

We reserve specific times for your treatment with Dr. Rice and her staff. Appointments that are 2 hours or more require special preparation by staff to make sure all needed materials and lab work are in order. We ask that you avoid changing appointments within 48 hours. **If 48 hours is not given your account will automatically be charged a \$45 missed appointment fee.** We ask that you make every effort to keep your reserved time. **Initial:** _____

UNPAID BALANCES

We will charge 2% interest per month on any unpaid balances as provided by State law. A \$29 late fee will be applied to your account for payments that are not made on time. There will also be a fee of \$30 for all returned checks. In the event that this account is turned over to collections, to protect the interest of Kellye N. Rice, D.M.D., P.L.L.C., please understand that you will incur the cost of collection costs, which will include reasonable attorney fees and court costs. **Initial:** _____

REFUNDS

Any refunds due will be issued after all insurance on the account have been paid. Any refunds due with the patient using a financing company will be issued less a processing fee. **Initial:** _____

CHANGE IN TREATMENT

Financial arrangements are made prior to the start of any treatment. If there is a change during treatment, I understand that before proceeding, I will be informed. This office has a rapid clearing nitrous vacuum system. Once I am on oxygen and the nosepiece is taken off, nitrous is out of my system so that I am able to discuss treatment, make treatment and financial decisions. **Initial:** _____

I have thoroughly read each section, understand, and agree to the terms of this policy.

Patient/parent signature: _____ Date: _____ Staff member initials: _____

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ADULT SLEEPINESS SCALE & HEALTH ASSESSMENT

Patient: _____ Date: _____ Age: _____ DOB: _____
LAST NAME FIRST NAME

EPWORTH SCALE – Using the following scale, choose the most appropriate number for each situation.

0 = No chance of **1 = Slight chance of** **2 = Moderate chance of dozing** **3 = High chance of dozing**

- | | |
|--|--|
| ___ Sitting and reading | ___ In a car, while stopped for a few minutes in |
| ___ Watching TV | ___ Lying down in the afternoon to rest |
| ___ Sitting inactive in a public place (eg: theater) | ___ Sitting and talking to someone |
| ___ A passenger in a car for an hour without a break | ___ Sitting quietly after lunch without alcohol |

Please add up all numbers to **TOTAL EPWORTH SCALE** _____

THORNTON SCALE – Using the following scale, choose the most appropriate number for each situation.

0 = Never **1 = Infrequently** **2 = Frequently** **3 = Most of the time**
(1 night per week) **(2-3 nights per week)** **(4 or more nights)**

- | | |
|---|---|
| ___ My snoring is loud | ___ My snoring requires us to sleep in separate rooms |
| ___ My snoring affects my relationship with my partner | ___ My snoring affects people when I am sleeping away from home |
| ___ My snoring causes my partner to be irritable or tired | |

Please add up all numbers to **TOTAL THORNTON SCALE** _____

SNORING, ENERGY & SLEEP - Using the following scale, choose the most appropriate number for each situation.

0 = No Snoring, energy level, sleep quality **10 = Loud snoring, energy level, sleep quality**

- ___ Rate your snoring level TODAY ___ Rate your energy level TODAY ___ Rate your sleep quality TODAY
- How often do you have morning headaches? How many times are you waking up per night? _____
 Never Daily Weekly Monthly Average hours of sleep per night? _____
- My bedtime partner notices me stop breathing ___ times per night. Comments _____

Please add up all numbers to **TOTAL SCALE** _____

- Y** **N** Do you feel excessively sleepy during the day?
- Y** **N** Do you feel burning, tingling or crawling sensations in your legs when you wake up?
- Y** **N** Have you had weight gain and found it difficult to lose?
- Y** **N** Do you have trouble falling asleep?
- Y** **N** Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
- Y** **N** Do you have trouble staying asleep once you fall asleep?
- Y** **N** Do you kick or jerk your legs while sleeping?
- Y** **N** Have you taken medication for, or been diagnosed with high blood pressure?

PATIENTS WITH EXISTING ORAL APPLIANCE THERAPY ONLY

- What changes have you notice with your oral appliance? _____
- How many hours are you wearing your appliance? _____
- Are you tracking your wear time and your snoring on SNORE LAB APP? _____
- Do you have questions or concerns regarding your oral appliance? _____
- How often are you turning your appliance? _____

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CHILDS SLEEP, BREATHING & HABIT QUESTIONNAIRE

Patient: _____ **Date:** _____ **Age:** _____ **DOB:** _____
LAST NAME FIRST NAME

Please indicate if your child has these behaviors by using the scale below to indicate the severity of these symptoms.

1-No Occurrence 2-Very Rarely 3-Occurs 2-4 times a week 4-Occurs 5-7 times a week 5-Occurs Daily

Does your Child:

- | | |
|--|---|
| <input type="checkbox"/> Snore at all | <input type="checkbox"/> Have labored, difficult, loud breathing at night |
| <input type="checkbox"/> Interrupts snoring where breathing stops for 4 sec. | <input type="checkbox"/> Allergic symptoms |
| <input type="checkbox"/> Excessive sweating while asleep | <input type="checkbox"/> Talks in sleep |
| <input type="checkbox"/> Struggles in math at school | <input type="checkbox"/> Struggles in Reading at School |
| <input type="checkbox"/> Wakes up at night | <input type="checkbox"/> Attention Deficit |
| <input type="checkbox"/> Restless Sleep | <input type="checkbox"/> Grinds Teeth |
| <input type="checkbox"/> Frequent Throat Infections | <input type="checkbox"/> Feels sleepy and/or irritable during the day |
| <input type="checkbox"/> Has a hard time listening and often interrupts | <input type="checkbox"/> Frequent Ear Infections |
| <input type="checkbox"/> Wet the bed | <input type="checkbox"/> Bluish color at night or during the day |
| <input type="checkbox"/> Have sensory issues | <input type="checkbox"/> Avoidance towards certain types of food |
- Speech Problems******* If yes, continue to speech questionnaire in the section below.

Speech Questionnaire: ONLY FILL OUT IF SPEECH ISSUES EXIST. Please check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Is it difficult to understand your child's speech? | <input type="checkbox"/> Speech sounds abnormal |
| <input type="checkbox"/> Frustrated when people can't understand speech | <input type="checkbox"/> Difficult to understand over the phone |
| <input type="checkbox"/> Others have difficulty understanding speech? | <input type="checkbox"/> Uses(M,N,NG)instead of (P,F,S,V,Z) sounds |
| <input type="checkbox"/> Nasal Speech? | <input type="checkbox"/> Sometimes omits consonants |
| <input type="checkbox"/> Swallowing problems w/ liquids & solids getting in nose? | <input type="checkbox"/> Hoarseness |