Kellye N. Rice, DMD

Cool Springs Laser Dentistry

Cosmetic and Family Dentistry with a Woman's Touch

CONFIDENTIAL DENTAL AND MEDICAL HISTORY

[Please print] **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) _____

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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

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

MEDICAL HISTORY

❒Allergies to anesthetics
❒AIDS or other immunosuppressive disorder
❒ Arthritis
❒ Artificial heart valves
❒ Asthma
❒Cancer
❒ Back problems
❒ Blood disease
❒ Chemical dependency
❒ Chronic diarrhea
❒ Circulatory problems
❒ Diabetes
❒ Ever taken Fen-Phen
❒ Epilepsy
❒ General allergies
❒ Headaches
❒ Heart problems
❒ Hemophilia
❒ Hepatitis, jaundice, liver disease
❒ High or Low blood pressure
❒ Joint replacement
❒ Lasik or eye surgery: Date: _____
❒ Psychiatric care
❒ Nervous problems
❒ Radiation treatment
❒ Recent weight loss
❒ Respiratory disease
❒ Rheumatic fever
❒ Sinus problems
❒ Special diet
❒ Swollen neck glands
❒ Stroke
❒ Ulcer
❒ Venereal disease
❒ 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. <u>I will not hold Dr. Rice</u> 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: _____

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

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

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

___ Sitting and reading
___ Watching TV
___ Sitting inactive in a public place (eg: theater)
___ A passenger in a car for an hour without a break
___ In a car, while stopped for a few minutes in traffic
___ Lying down in the afternoon to rest
___ Sitting and talking to someone
___ 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 (1 night per wk) 2 = Frequently (2-3 nights per wk) 3 = Most of the time (4 or more per wk)

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

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

SNORING	**ENERGY**	**SLEEP**
On a scale of **0 = None** & **10 = Loud**	On a scale of **0 = Low & 10 = High**	On a scale of **0= Poor & 10 = Great**
Rate your snoring level **TODAY** ____	Rate your energy level **TODAY** _____	Rate your sleep quality **TODAY** _____

How often do you have morning headaches? ❒Never ❒ Daily ❒ Weekly ❒ Monthly

How many times do you wake up per night? _____ per night Average hours of sleep per night? _____ hours

My bedtime partner notices me stop breathing _____ times per night Comments _____

❒ **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:

____ Snore at all

____ Interrupts snoring where breathing stops for 4 sec.

____ Excessive sweating while asleep

____ Struggles in math at school

____ Wakes up at night

____ Restless Sleep

____ Frequent Throat Infections

____ Has a hard time listening and often interrupts

____ Wet the bed

____ Have sensory issues

____ Have labored, difficult, loud breathing at nigh

____ Allergic symptoms

____ Talks in sleep

____ Struggles in Reading at School

____ Attention Deficit

____ Grinds Teeth

____ Feels sleepy and/or irritable during the day

____ Frequent Ear Infections

____ Bluish color at night or during the day

____ 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.

____ Is it difficult to understand your child's speech?

____ Frustrated when people can't understand speech

____ Others have difficulty understanding speech?

____ Nasal Speech?

____ Swallowing problems w/ liquids & solids getting in nose?

____ Speech sounds abnormal

____ Difficult to understand over the phone

____Uses(M,N,NG)instead of (P,F,S,V,Z) sounds

____ Sometimes omits consonants

____ Hoarseness