MEDICAL HISTORY

Patient _____ Birth Date _____

Pharmacy Name _____ Pharmacy Phone Number _____

Are you allergic to any medications? Yes No Are you allergic to latex? Yes No

Are you allergic to any metals? Yes No

List all medications you are allergic to: _____

Are you taking any medications now? Yes No Herbals or dietary supplements? Yes No

List all medications and supplements you presently take: _____

_____

WOMEN, Are you Pregnant? ***Yes*** ***No*** ***Months Gestation*** _____

Do you think you are pregnant? ***Yes*** ***No*** ***Taking Birth Control Pills?*** ***Yes*** ***No***

Are you nursing? ***Yes*** ***No***

Have you ever had problems with dental anesthetics? Yes No Explain: _____

How long since your last Dental Visit? _____ Dental Cleaning? _____ X-Rays? _____

What brings you to our office? _____ Do you have dental phobias? _____

Have you ever considered straightening your teeth or improving your smile? _____

Your Overall General Health Is: Excellent / Good / Fair / Poor Major Surgeries in last 5 years: _____

Do you smoke, use tobacco, alcohol or drugs? _____ If yes: how often? _____

Physician's Name: _____ Physician's Phone Number: _____

Is there any health issue you would like to discuss with the Doctor or office member privately? Yes No

Please circle any of the following which apply to you either in the past or present:

Heart Disease or Murmur, Congenital Heart Lesions
Mitral Valve Prolapse / MVP
Rheumatic Fever
High Blood Pressure / Low Blood Pressure
Sleep Apnea / CPAP
Lung Disease or Tuberculosis
Stroke
Diabetes
Glaucoma
Muscular Dystrophy /Epilepsy / Seizures
Hepatitis
Fainting Spells
Joint Replacement (When/What) _____
Dental Implant (When/What) _____
Cancer (Type/Treatment) _____

Night Sweats
Allergies-Seasonal or other: _____
Jaundice
Drastic Weight Loss
Atrial Fibrillation
Asthma / Hay Fever
Migraine Headaches
Sinus Trouble
Excessive Thirst or Urination
Ulcers
Anemia
Blood Transfusion or Prolonged Bleeding
Arthritis
Lymph Node Enlargement (Swollen Glands)
Thyroid Problems _____

If you have circled any of the above or indicated "yes" please explain below: _____

_____

Consent for Treatment

I hereby authorize Dr. Sandford, her Associate, or her Designated Team member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Sandford or her Associate to make a thorough diagnosis of my or my dependent's dental needs. Upon such diagnosis, I authorize Dr. Sandford or her Associate to perform all recommended treatment mutually agreed upon by me and Dr. Sandford or her Associate and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and or other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete description of any possible complications. I agree to be responsible for payment and services rendered on my behalf and of my dependents. I understand payment is due in full at the time of service unless other arrangements have been made prior to my treatment.

Acknowledgment and Release

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Should further medical information be needed, you have my permission to ask the respective health care provider or agency, which may release it to this office.

A parent or legal guardian must sign below if the patient is less than 18 years old.. If you were assisted with this form please enter the name and phone number of the person assisting you today: _____

Patient Signature _____ Date _____ Witness _____

Dentist Signature _____ Date _____

Merrily Sandford, DDS and Associates

Patient Information

Patient Name:_____ Today's Date:_____

Home Address:_____ City:_____ Zip:_____

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

Social Security #:_____ Male/Female Married / Single / Child / Other

Birth Date:_____ Drivers License #:_____

Employer Name:_____ City, State:_____

Appointment Confirmation E-Mail Address_____

Subscriber Dental Insurance Information

Name of Subscriber:_____Relationship to Patient:_____

Subscriber SS# or Insurance ID #:_____Subscriber Birth Date:_____

Insurance Company:_____Phone:_____

Group or Policy #:_____Effective Date:_____

Subscriber Employer:_____City and State:_____

Responsible Party Information

Name:_____Relationship:_____

Social Security #:_____Birth Date:_____Married / Single / Other_____

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

Address:_____

Referral Information

Whom may we thank for referring you to our practice? Patient / Website / Doctor / Walk By / Other

Please list their Name:_____

Emergency Contact

Who should we contact in case of an emergency?_____

Relationship:_____Phone:_____

Important Office Policies That You Need To Know

- IAOMT (International Academy of Oral Medicine and Toxicology) protocols are used in our office for amalgam or metal removal. We do not vary from the use of these protocols.

- All large cosmetic and sedation treatment must be prepaid at least one week in advance of your appointment.

- Treatment requiring 3 (three) hours of chair time or more will require a 50% (fifty percent) non refundable payment.

- **We only see 1 (one) patient at a time and your appointment RESERVATION is made especially for you. We TRUST you will attend your reserved appointment time. Last minute cancellations may affect many other patients. If within 24 hours of your reserved appointment time you cancel your appointment a cancellation fee of $200 per reserved treatment hour will be charged.**

Dental Insurance Overview and Account Guarantee

- Your Dental Insurance is a contract between you, your employer and the dental insurance company. Dr. Sandford and her Associates are not a party to that contract. The doctors in this office are considered *Out of Network Providers* except for Delta Premier, Cigna Radius and Connection Dental.

- Not all dental services are a covered benefit in all contracts and it is your responsibility to know what your plan covers. Only your dentist can diagnose and prescribe needed treatment, not your dental insurance company.

- We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region. If your dental insurance company uses a different fee schedule you will be responsible for any balance they choose not to pay.

- We will process and submit your dental insurance claim on your behalf to your Insurance Company to pay your benefit in full. If your dental insurance company does not pay for your treatment in full for any reason, we will expect payment for your remaining outstanding balance to be paid in full immediately.

- We are only **ESTIMATING** the portion of your balance you are responsible for at the time of treatment. Your dental insurance company can **DOWNGRADE** or **DENY** a treatment procedure thereby obliging us to **COLLECT** the remaining balance from you.

- **If my dental insurance company denies or downgrades my claim I understand that I am still responsible to pay my entire balance in full.**

Patient Signature _____ Today's Date _____

MERRILY SANDFORD, DDS and Associates
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

I, _____, give written permission to discuss all my treatment, account information or scheduling with the following individuals below:

_____ _____

Person I give permission to discuss account Person I give permission to discuss account

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

MERRILY SANDFORD, DDS & ASSOCIATES
THE CENTER FOR HEALTHY DENTISTRY

Adult Sleep & Breathing Questionnaire

Date: _____

Patient 's Name: _____

Patient's Date of Birth: _____ Age: _____

Male _____ Female _____

Have you ever had a sleep test administered? _____ yes _____no

If yes - when did you have your last sleep test? _____

Have you been diagnosed with Sleep Apnea? _____yes _____no

Do you currently use a CPAP or Sleep Appliance for Sleep Apnea? _____yes _____no

Are you happy with your CPAP or Sleep Appliance? _____yes _____no

If you are not happy - why? _____

_____

_____

How often do you get out of bed to use the restroom during the night? _____

	Yes	No
Do you usually wake feeling tired and unrested?	☐	☐
Do you habitually snore?	☐	☐
Have you been diagnosted with Hypertension/High Blood Pressure?	☐	☐
Do you often suffer from waking headaches?	☐	☐
Do you regularly experience daytime drowsiness or fatigue?	☐	☐
Do you have blocked nasal passages?	☐	☐
Has anyone observed you stop breathing during your sleep?	☐	☐
Do you ever wake up choking or gasping?	☐	☐
Do you grind your teeth while sleeping?	☐	☐
Is your neck circumference greater than 40 cm/ 15.75" ?	☐	☐
Is your Body Mass Index (BMI) more than 35?	☐	☐

BMI Formula BMI = $\frac{\text{(your weight in pounds X 703)}}{\text{(your height in inches X your height in inches}}$