T. LANCE COLLIER, DMD, LLC

Family Practice *of* General Dentistry

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your overall health status is very important to developing a safe and effective treatment plan that suits your dental needs. Health problems and medications can affect the course of dental treatment you receive. Please answer the following questions honestly.

NAME: ______________________ **DATE**: ______________________

Are you currently under the care of a physician? ☐YES ☐NO What was the date of your last physical exam? ______________

Physician's name: ______________________ Physician's phone#: ______________

Please list any medications or dietary supplements that you are currently taking:

____

____

____

Have you ever been hospitalized or had a major operation?	☐YES	☐NO	Explain: ______________
Do you take, or have you taken, Phen-Fen, Redux, or other diet pills?	☐YES	☐NO	Explain: ______________
Are you on a special diet?	☐YES	☐NO	Explain: ______________
Do you smoke or use tobacco?	☐YES	☐NO	How much? ________packs/day or dip________
Do you use controlled substances?	☐YES	☐NO	Explain: ______________
Do you take anticoagulants/blood thinners? (including daily aspirin)	☐YES	☐NO	Explain: ______________
Have you ever had excessive bleeding requiring special treatment?	☐YES	☐NO	Explain: ______________
Have you ever had a joint replacement?	☐YES	☐NO	Explain: ______________

Do you have an ALLERGY to any of the following:

☐Aspirin ☐Penicillin ☐Latex ☐Codeine/Other Narcotic ☐Sulfa ☐Dental Anesthetics/Novacaine

☐Acrylic ☐Metal ☐Other: ______________________

<u>FOR WOMEN</u>

Are you pregnant? ☐YES ☐NO Due date:______________ Name of Obstetrician: ______________

Are you attempting to become pregnant? ☐YES ☐NO Obstetrician's phone#: ______________

Are you breastfeeding or nursing? ☐YES ☐NO Are you taking birth control pills? ☐YES ☐NO

Due to new medical research involving the dental impact of medications used for the treatment of osteoporosis and in some cancer therapies, it is important that we know if you have taken any of the following drugs:

<u>Oral Medications:</u>	<u>IV Medications</u>	
☐**Actonel**	☐ **Aredia**	If so, how long have you been taking this medication: ______________
☐**Boniva**	☐ **Bonefos**	If you no longer take the medication, how long did you take the medication and when
☐**Fosamax**	☐ **Boniva IV**	did you stop using it? ______________
☐**Fosamax plus D**	☐ **Reclast**	*For IV medications:*
☐**Skelid**	☐ **Zometa**	When were you last administered the medication? ______________
☐**Didrone**		Will you be treated with this again in the future? ______________

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MEDICAL HISTORY, Continued

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

Recent illness-past year	☐YES ☐NO	Pneumonia	☐YES ☐NO	Frequent headaches	☐YES ☐NO
Recent cough or cold	☐YES ☐NO	Anemia/Low iron	☐YES ☐NO	Convulsions	☐YES ☐NO
Heart trouble	☐YES ☐NO	Sickle Cell Disease	☐YES ☐NO	Epilepsy/Seizures	☐YES ☐NO
Irregular heart beat	☐YES ☐NO	Hemophilia	☐YES ☐NO	Cerebral Palsy	☐YES ☐NO
Arrhythmia	☐YES ☐NO	Scarlet fever	☐YES ☐NO	Psychiatric treatment	☐YES ☐NO
Heart Attack/MI	☐YES ☐NO	Bruise easily	☐YES ☐NO	Alzheimer's Disease	☐YES ☐NO
Angina/Chest pain	☐YES ☐NO	Stomach ulcers	☐YES ☐NO	Cancer	☐YES ☐NO
Heart murmur	☐YES ☐NO	Intestinal Disease	☐YES ☐NO	Chemotherapy	☐YES ☐NO
Congenital heart defect	☐YES ☐NO	Frequent diarrhea	☐YES ☐NO	Radiation treatment	☐YES ☐NO
Rheumatic fever	☐YES ☐NO	Gastric Bypass	☐YES ☐NO	Tumors or Growths	☐YES ☐NO
Mitral valve prolapse	☐YES ☐NO	Acid reflux/GERD	☐YES ☐NO	Leukemia	☐YES ☐NO
Prosthetic heart valve	☐YES ☐NO	Blood transfusion	☐YES ☐NO	Recent weight loss	☐YES ☐NO
Pacemaker/Defibrillator	☐YES ☐NO	AIDS/HIV positive	☐YES ☐NO	Arthritis/Gout	☐YES ☐NO
High blood pressure	☐YES ☐NO	Hepatitis A	☐YES ☐NO	Swelling of joints	☐YES ☐NO
Low blood pressure	☐YES ☐NO	Hepatitis B or C	☐YES ☐NO	Rheumatism	☐YES ☐NO
Lung disease	☐YES ☐NO	Tuberculosis	☐YES ☐NO	Yellow jaundice	☐YES ☐NO
Congestive heart failure	☐YES ☐NO	Cold sores/Fever blisters	☐YES ☐NO	Liver Disease	☐YES ☐NO
Shortness of breath	☐YES ☐NO	Herpes	☐YES ☐NO	Kidney Disease	☐YES ☐NO
Asthma	☐YES ☐NO	Shingles	☐YES ☐NO	Renal dialysis	☐YES ☐NO
Anaphylaxis	☐YES ☐NO	Venereal Disease	☐YES ☐NO	Thyroid Disease	☐YES ☐NO
Hay fever	☐YES ☐NO	Hives or rash	☐YES ☐NO	Parathyroid Disease	☐YES ☐NO
Sinus trouble	☐YES ☐NO	Hypoglycemia	☐YES ☐NO	Cortisone or ACTH	☐YES ☐NO
COPD/Emphysema	☐YES ☐NO	Diabetes	☐YES ☐NO	Glaucoma	☐YES ☐NO
Bronchitis	☐YES ☐NO	Excessive thirst	☐YES ☐NO	Contact Lenses	☐YES ☐NO
Tonsillitis	☐YES ☐NO	Stroke/CVA	☐YES ☐NO	Drug Addiction	☐YES ☐NO
Chronic cough	☐YES ☐NO	Fainting spells/Dizziness	☐YES ☐NO		

Additional comments: ____

____

____

____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need in the normal course of diagnosis and treatment. I understand that I am financially responsible for all charges.

Signature: ______________________________ Date: ______________________

T. LANCE COLLIER, DMD, LLC

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NEW PATIENT REGISTRATION

Please provide us the following information.

GENERAL INFORMATION

Name____Preferred:________________________

Address____

City______________________________State________Zip______________________________________

Email Address____

Home Phone (________)__________________________Work Phone (________)_________________________

Cell Phone (________)___________________________ FAX (________)______________________________

Date of Birth________/________/____________SSN____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

EMPLOYMENT INFORMATION

Employer______________________________________Occupation/Job Title____________________________

Employer's Address____

SPOUSE INFORMATION – OR – PARENT/GUARDIAN (if patient is a child/minor)

Spouse's Name____

Employer____ Work Phone (__________)______________________

SSN____Date of Birth___________/___________/_____________

RESPONSIBLE PARTY. WHO IS RESPONSIBLE FOR YOUR CHARGES TODAY?

Responsible Party's Name____

Address____

City____________________________________State_____________Zip_______________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name____

Relationship to Patient________________________________Phone No.(__________)____________________

PHYSICIAN CONTACT INFORMATION

Name of Primary Care Physician or Clinic____

Address____Phone No. (_________)________________

Date of Last Medical Exam____

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ EXISTING PATIENT/FRIEND ☐ INSURANCE CARRIER ☐ INTERNET SEARCH

WHOM MAY WE THANK FOR REFERRING YOU?: ____

INSURANCE INFORMATION

Insurance Co.____

Name of Insured____

Individual No.________________________ Group No.________________________

Insured's Date of Birth______/_______/________ Insured's SSN________________________

Relationship to Insured__________________Insured's Employer________________________

APPOINTMENT REMINDERS, CANCELLATION, NO SHOW & FINANCIAL POLICY

APPOINTMENT REMINDER, CONFIRMATION, LATE ARRIVAL, NO SHOW AND CANCELLATION POLICIES

As a complimentary service, our office utilizes an automated system for appointment reminders and confirmations. The system is structured using emails, text messages, and automated phone calls. This works well if you are "on-the-go" and prefer to have Appointment Reminders electronically delivered to your Inbox or Mobile Phone. Appointments can be confirmed by clicking a link in reminder emails, by responding with the letter "C" to text reminders, or by following instructions given during automated phone calls. Our office will also contact you by phone directly to remind you of your appointment.

☐ I authorize T. LANCE COLLIER, DMD, LLC to send my appointment reminders electronically via Email and Text Message.

Please plan to arrive 10-15 minutes early for your scheduled appointments. As delays in the daily treatment schedule can adversely impact treatment for other patients, excessively late arrival for an appointment may require rescheduling at the practice's discretion. Though, we do understand that unforeseen issues can arise on occasion and you may need to cancel or reschedule your appointment, please be aware that **Your treatment appointments are specifically reserved for you.** It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken or missed appointment is a loss to three people – the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment. Thus, *we respectfully request at least 48 hours advance notice for canceling or rescheduling an appointment; otherwise, a $50 fee may be assessed to your account, and may be required to be paid prior to scheduling another appointment.*

FINANCIAL POLICY STATEMENT:

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. **Payment is due at the time services are rendered.** Our office is an in-network provider for a select group of dental benefits carriers. As a courtesy to you, we may prepare and submit forms and reports to assist you in obtaining maximum benefits available, however the dentist's treatment recommendations are not affected by the presence or absence of dental benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you and your chosen benefits carrier. Thus **we are not obligated to communicate with your insurance carrier to gather information on your eligibility and limits of benefits**. Patients with dental insurance are required to pay their estimated deductibles and co-insurance at the time of treatment. Following claim payment, any remaining balance is the patient's responsibility. Please be advised, though our office will make every effort to communicate to you accurate information with regards to your dental benefits, **we are not and cannot be responsible for any inaccuracy of information conveyed from a benefits carrier.** You are the policy holder, therefore an insurance carrier's obligation is to you and not to our office. Irrespective of any dental insurance benefits that might exist, you are always responsible for the entire cost of dental treatment. Those patients whose insurance carrier engages exclusively in direct reimbursement are required to pay for services in full at time of treatment. In the event a patient's balance becomes more than 90 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. We will be happy to discuss any special needs in the handling of your account. We accept cash, checks and credit cards.

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS CORRECT AND THAT I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

Waiver or any breach of any term or condition shall not constitute a waiver of any other term or condition.

X Signature of Patient or Guardian____________________________Date______________

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INITIAL CONSULTATION FORM

To help us get to know you, and to assist in learning your dental concerns, please provide us the following information.

NAME:______________________________________DATE:______________________________________

In your own words, what is your main concern regarding your visit today?_______________________________

____

How long have you lived in this area?____________Approximate Date of your Last Dental Visit: ______________

Previous Dentist:__________________________Previous Dentist's Phone #__________________________

Is there anything you would like to express about your dental health or past dental treatment?____________________

____

How would *YOU* rate your dental health?
□ Excellent/Above Average □ Good/Average □ Fair/Average □ Poor/Below Average

Are *you* satisfied with your smile? □YES □NO *WHY?*______________________________

Do you *like* your smile? □YES □NO ______________________________

Do you *LOVE* your smile? □YES □NO ______________________________

Are you in dental discomfort/**pain** today?	□YES	□NO	Does your jaw ever **pop**, **click** or **lock**?	□YES	□NO
Are any of your teeth **loose**?	□YES	□NO	Do you ever have **pain** or **tension** in front of your ears, on sides of the face, or in your jaws?	□YES	□NO
Are your teeth sensitive to **hot** or **biting/chewing pressure**?	□YES	□NO	Have you ever been treated for **TMJ** or **TMD**?	□YES	□NO
Have you ever **broken or chipped** a tooth?	□YES	□NO	Does your **bite feel strange or odd**?	□YES	□NO
Have you noticed that any of your teeth may look **worn**?	□YES	□NO	Does any of your previous or existing dental work feel loose or damaged?	□YES	□NO
Are you **missing** any teeth?	□YES	□NO	Have you had **orthodontic** treatment?	□YES	□NO
Do you **clench** or **grind** your teeth?	□YES	□NO	Do you currently wear any type of **dental appliance**(**orthodontic retainer** or **TMJ splint**)?	□YES	□NO
Are your teeth sensitive to **cold** or **sweets**?	□YES	□NO	Do you or have you suffered from **Acid Reflux**?	□YES	□NO
Do you have frequent "tension" **Headaches?**	□YES	□NO	Do you have any history of an **eating disorder**?	□YES	□NO
Do your **gums bleed** when you floss or brush?	□YES	□NO	Do you or have you been told you **snore**?	□YES	□NO
Have you ever been treated for **gum disease**?	□YES	□NO	Have you been diagnosed with **Sleep Apnea** or do you wear a **CPAP** at night to sleep?	□YES	□NO
Have you ever had a **gum surgery or graft**?	□YES	□NO	Have you ever been diagnosed with **oral cancer**?	□YES	□NO
Are you concerned with having **bad breath**?	□YES	□NO	Do you feel that you suffer from "**dry mouth**?"	□YES	□NO
Do you wish your teeth were **whiter or brighter**?	□YES	□NO	Do you have **anxiety** about dental work?	□YES	□NO

Further explanation of *YES* answers from dental history questionnaire:

____

____

Are there any specific dental treatments that you are interested in learning more about?

____

____

WHAT IS THE MOST IMPORTANT THING TO YOU IN CHOOSING A DENTIST OFFICE FOR YOU AND YOUR FAMILY'S NEEDS?

____

SLEEP, AIRWAY, AND BREATHING SURVEY

The science of dentistry is evolving to uncover more and more the inter-relationship of our systemic health and our oral health. The presence of airway problems or sleep disturbances has been found to have a profound impact on the status of your oral health, and may be relevant when selecting among dental treatment options which may have an effect on the severity of the manifestation of these conditions. The potential impact on your general health may be profound, thus, we ask you to complete the following surveys.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. If you have not done some of these things recently, think about how they have affected you in the past.

Use the following scale to 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

SITUATION	**Chance of Dozing**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	□YES	□NO
Do you often feel tired, fatigued, or sleepy during the daytime?	□YES	□NO
Has anyone observed you stop breathing during your sleep?	□YES	□NO
Do you have or are you being treated for High Blood Pressure?	□YES	□NO
Is your BMI* more than 35 kg/m2?	□YES	□NO
Are you 50 or older?	□YES	□NO
Is your neck circumference greater than 40 cm?(Size 16 shirt)	□YES	□NO
Are you male?	□YES	□NO

*Our staff can assist you with your BMI calculation

Patient Dental Philosophy Survey

Dr. Collier and Staff would like to thank you for entrusting us with your dental needs and welcome you to our Family Practice. We'll start by sharing with you what our guiding beliefs are for our patients. Fundamentally, it is the Golden Rule – We seek to treat our patients the way we want to be treated. This starts with compassion, respectfulness and consideration. From there we train ourselves daily to execute clinical excellence to the best of our abilities. Our philosophy is to help each patient achieve the highest level of dental health that is appropriate for them individually, recognizing that not all patients have the same dental needs or desires.

With that in mind and to help us better serve you, we ask that you identify how you would like to be seen in our office by checking which of the following levels feels appropriate for you at this time. Please understand that this is intended as an aid for our staff in meeting your expectations of care. You may choose a different path at any time you wish simply by discussing your desires with any staff member you feel comfortable.

Please check the box from the following that most accurately describes your priorities at this time.

❑ *First Tier*: **REGENERATIVE CARE**: Patients at this level have the highest value for their dental health and appearance. They desire a complete dental examination and expect to be informed of all findings and the potential consequences of each problem. Ultimately, they actively desire to be involved in creating a long term master plan for their dental health and wellness which includes choosing the most comprehensive and longest lasting solutions to their problems and concerns. Generally, patients at this level will not limit treatment decisions based on dental benefit or insurance coverages, and prefer to choose the options that accomplish the most ideal results.

❑ *Second Tier*: **PROACTIVE CARE**: Patients who choose this level of care generally desire a thorough examination and want to be involved in the prevention of present and future dental problems. These patients value regular cleanings and exams in order to track changes over time. At this tier, patients can be insurance-sensitive and may allow dental benefit coverage to limit treatment choices. However, they desire a more proactive approach to maintaining good oral health. Nevertheless, since maintenance of their current state of health is a main priority, they may only choose intermediate repair solutions, and defer more comprehensive treatment plans that address restoring ideal oral health. Example: A patient that will address needs so long as dental benefits will contribute towards costs, or a patient that will proceed with recommended treatment but at a pace dictated by the annual limitations of their benefit policy.

❑ *Third Tier*: **REACTIVE CARE**: A patient at this level is generally only interested in addressing the most urgent problems, usually seeks dental care only on an emergency basis when in pain, and does not necessarily desire a comprehensive exam or plan to accomplish predictable oral health. At this tier, regular cleanings and exams are not a priority. In choosing treatment options, this patient typically prioritizes choices based primarily on cost and desires treatment to deal with issues quickly and as efficiently as possible. Example: A patient that would choose to extract a salvageable tooth over options to preserve a tooth for years to come.

We hope these different levels make sense to you. We have a genuine desire to meet or exceed your expectations, and as we stated before, it is not uncommon for patients to change levels after beginning treatment with us. We look forward to caring for your needs and helping you achieve the level of dental care most appropriate for you.