OAKPORT DENTAL

NEW PATIENT PAPERWORK

PATIENT INFORMATION **DATE:** _____

Last Name _____ First Name _____ MI____

Street Address_____City_____State___Zip Code_____

Date of Birth_____ SSN_____Email_____

Cell Phone_____Work Phone_____

Driver License #_____

Emergency ContactPerson_____ Phone #_____

RESPONSIBLE PARTY

Are you the responsible party for this account? Yes or No

If no, list a responsible party? Relationship to Patient _____Phone # _____

Last Name_____ First Name_____

Street Address_____ City_____ State____ Zip Code _____

INSURANCE INFORMATION

Primary Insurance Carrier_____ Member ID_____

Address_____ City_____ State_____ Zip Code_____

Subscriber's Name_____ Insurance Carrier Phone#_____

How did you hear about our office? _____

Patient Signature_____

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
Yellow Jaundice ○ Yes ○ No			

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Financial Agreement

I, the undersigned, do hereby agree to pay the fees for services rendered. I further agree that payment is due when such services are rendered, unless prior arrangements are made.
I understand that unpaid balances will be considered delinquent after thirty (30) days and in default after forty-five (45) days, after which interest will be charged at a rate of 1 1/2% per month on the unpaid balance (annual rate of 18% or the legal interest rate, whichever is lower).
In the event of a legal suit or collection actions to enforce payment of the unpaid balance, I agree to pay such attorney fees, court costs and/or collection fees, as deemed reasonable.
I waive venue jurisdiction and submit myself to the jurisdiction and venue of the Courts of Seminole County, State of Florida.

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Oakport Dental Sanford PLLC, or other agent of their choosing, for benefits that may be due and payable under the insurance coverage for myself and/or my co-insureds.
I authorize utilization of this application or copies thereof for the purpose of processing claims and affecting payments. I further acknowledge that this agreement of benefits does not in any way relieve me of liability and that I remain financially responsible to Oakport Dental Sanford PLLC for any fees unpaid by my insurance company or dental plan.

Missed Appointments

I agree to keep my scheduled appointments. I understand that time is set aside for me and it is my obligation to keep scheduled appointments. I further understand that, unless 2 business days advance notice is given, I will be liable to pay a broken appointment fee.

Patient Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Oakport Dental Sanford

2421 Maple Avenue

Sanford, Fl. 32771

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy Oakport Dental Sanford's of *HIPAA Notice of Privacy Practices.*

I understand that Oakport Dental Sanford's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Oakport Dental Sanford's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Oakport Dental Sanford's *HIPAA Notice of Privacy Practices*, I may contact Dr. Craig Aebi .

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Oakport Dental Sanford's will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Oakport Dental Sanford's's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask front office, noted above, for assistance.

_____ Patient Signature	_____ Date
_____ Signature of Personal Representative	_____ Print Name of Personal Representative
	_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Oakport Dental Sanford's made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices.* In spite of these efforts,Oakport Dental Sanford's was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

Oakport Dental

Sleep Scale Questionnaire

NAME: _____ DATE: _____

AGE: ___ MALE: ___ FEMALE: ___ WEIGHT: _____ HEIGHT: _____

CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS

HAVE YOU BEEN DIAGNOSED WITH SLEEP APNEA?	**YES NO**
DO YOU WEAR A C-PAP WHILE SLEEPING?	**YES NO**
DO YOU FEEL SLEEPY OR FATIGUED DURING THE DAY?	**YES NO**
DO YOU FEEL THE NEED TO TAKE A NAP TO MAKE IT THROUGH THE DAY?	**YES NO**
DO YOU STOP BREATHING, GASP, OR CHOKE WHILE ASLEEP?	**YES NO**
DO YOU SNORE?	**YES NO**
DO YOU HAVE HIGH BLOOD PRESSURE?	**YES NO**

HOW LIKELY ARE YOU TO FALL ASLEEP IN THE FOLLOWING SITUATIONS?

CHOOSE THE APPROPRIATE NUMBER FOR EACH SITUATION

0- NEVER / 1- SLIGHT CHANCE/ 2- MODERATE CHANCE /3- HIGH CHANCE

WHILE SITTING AND READING __

WATCHING TV __

PUBLIC PLACES (MOVIES, MEETINGS, ETC.) __

PASSENGER IN CAR __

LYING DOWN TO REST __

SITTING AND TALKING TO FRIENDS __

SITTING QUIETLY AFTER LUNCH __

STOPPED IN TRAFFIC FOR A FEW MINUTES __