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Welcome to Westlake Family Dentistry

Patient Registration Information

Please fill out new patient forms in ink and don't hesitate to ask if you have any questions!

Name: _____ _____ _____

First Middle Last Preferred Name Date of birth Age

Address: _____ _____

City State Zip code Social Security #

☐ Home Phone: _____ ☐ Cell: _____ ☐ Work: _____

**Mark Preferred Number

☐ Single ☐ Married ☐ Divorced ☐ Minor Place of Employment: _____

Referred by: ☐ Friend/Family [Name] _____ ☐ Dr. _____

☐ Direct Mail ☐ Walk-in ☐ Insurance _____ ☐ Internet _____

Email Address: _____

Responsible Party Information (If under age 18 only)

Name: _____ _____

First Middle Last Date of Birth

Address: _____ _____

City State Zip code Social Security #

☐ Home Phone: _____ ☐ Cell: _____ ☐ Work: _____

**Mark Preferred Number

Place of Employment: _____ Relationship to Patient: _____

Medical Insurance Information

Name of Insured: _____ _____

First Middle Last Date of birth

Address of Insured: _____ _____

City State Zip code Social Security #

Phone: _____ Place of Employment: _____ Relationship to Patient: _____

Insurance Company: _____ Phone: _____ Member ID: _____

Emergency Contact Information (Outside of immediate household)

Name: _____ Home Phone: _____ Cell Phone: _____

Financial Responsibility

We will gladly check your insurance benefits, give you an estimate for any portions that may be due by you and bill your insurance at the time of treatment.

Payment for your estimated portion is due at the time services are rendered. For your convenience we accept the following methods of payment: **Cash, Checks, Visa, MasterCard, Discover, HSA/FSA cards & CareCredit.**

****Balances over 30 days may incur a 1.5% monthly finance charge.**

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I understand that chronically missed and/or canceled appointments may result in a $50-$100 fee. I authorize Westlake Family Dentistry to bill my insurance company as well as release any information needed to do so and assign benefits to Bradley E. Sievert, DMD, PC.

Printed Name: _____ Signature: _____ Date: _____

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Patient Dental History

Name: _____ Westlake Family Dentistry

What is your primary reason for your visit today? _____

When was your last dental visit? _____ Name of current dentist: _____

Have your previous dental experiences been favorable? _____ If not, please explain: _____

_____

Have you experienced any of the following:	Yes	No		Yes	No
Sensitivity to hot or cold……..	☐	☐	Root canal treatment…….....	☐	☐
Sensitivity to sweets or sour……	☐	☐	Frequent headaches……..	☐	☐
Sensitivity to pressure/biting…….....	☐	☐	Habitual grinding or clenching of teeth…..	☐	☐
Bleeding gums while brushing/flossing……..	☐	☐	Jaw joint pain……...	☐	☐
Frequently bite cheeks/lips……...	☐	☐	Clicking or popping of jaw……..	☐	☐
Sores or lumps in or around your mouth……..	☐	☐	Pain in ear or side of face…….……	☐	☐
Gum recession……..	☐	☐	Crooked teeth…….……..	☐	☐
Periodontal (gum) treatment……	☐	☐	Does food catch between your teeth ……....	☐	☐
Cracked or broken teeth……	☐	☐	Orthodontic treatment…….……	☐	☐
Difficult extractions……..	☐	☐	Discolored teeth ……..	☐	☐

Medical History

This information will help us in preventing serious medical complications. Please let us know if there is anything not listed, that you feel we should know about, in regards to your medical/dental health.

Name of Physician: _____ Date of last physical: _____

Are you under medical treatment now? _____ If yes, describe: _____

Have you been hospitalized or had a serious illness in the last 3 years? ____ Explain: _____

Do you smoke or use smokeless tobacco? _____ If yes, how often? _____ How many years? _____

Please list any medications, including non-prescription medicine:

_____
_____
_____
_____
_____
_____

Allergies or reactions to:	Y	N
Local anesthetics……..…..	☐	☐
Barbiturates/Sedatives……...	☐	☐
Aspirin……...	☐	☐
Latex……..	☐	☐
Sulfa drugs.……...	☐	☐
Antibiotics……	☐	☐
Please list:_____		
Other: _____		
Women: Are you pregnant?	☐	☐

Have you had, at any time, any of the following:	Y	N		Y	N
Aids/HIV……	☐	☐	Heart Murmur……	☐	☐
Anemia……...	☐	☐	Hepatitis……	☐	☐
Angina/Chest pain……..	☐	☐	Herpes……	☐	☐
Artificial joint/Implant...	☐	☐	High Blood Pressure..	☐	☐
Asthma/resp. problems...	☐	☐	Jaundice……	☐	☐
Bleeding problems……..	☐	☐	Kidney Disease……..	☐	☐
Cancer……	☐	☐	Liver Disease…….	☐	☐
Chemotherapy……	☐	☐	Pacemaker…….	☐	☐
Diabetes……	☐	☐	Psychiatric care…….	☐	☐
Dizziness/Fainting……..	☐	☐	Sleep Apnea…….	☐	☐
Easily Winded……	☐	☐	Stomach issues/ulcers	☐	☐
Epilepsy/Seizures……...	☐	☐	Stroke……	☐	☐
Emphysema/COPD……	☐	☐	Thyroid problems…..	☐	☐
Glaucoma/Cataracts……	☐	☐	Tuberculosis……..	☐	☐
Heart Attack……...	☐	☐	Use of CPAP……	☐	☐
Heart Disease……..	☐	☐	Other _____		

I have read and understand the above information and have answered truthfully to the best of my knowledge. I understand that providing incorrect information may be dangerous to my medical/dental health.

Printed Name: _____ Signature: _____ Date: _____

Reviewed by: Initials_____ Date_____ Initials_____ Date_____ Initials_____ Date_____ Initials_____ Date_____

Sleep Questionnaire

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Please answer the following questions to the best of your knowledge.

	Y	N	Notes
Has anyone ever told you that you snore? …….	☐	☐	_____
Do you feel tired or easily fatigued during the day? …….	☐	☐	_____
Do you wake up with a dry mouth or sore throat? ……	☐	☐	_____
Do you feel you have restless or fitful sleep? ……	☐	☐	_____
Do you experience choking, snorting or gasping during sleep? ……	☐	☐	_____
Do you awaken in the morning still feeling tired or groggy? ……	☐	☐	_____
Do you suffer from getting up frequently at night? ……...	☐	☐	_____
Do you experience forgetfulness and difficulty concentrating? ……	☐	☐	_____
Do you fall asleep sitting, reading or watching TV? …….	☐	☐	_____
Do you fall asleep while driving? ……..	☐	☐	_____
Do you get morning headaches or frequent headaches? ……	☐	☐	_____

How many each week? _____ Each month? _____

Have you had, <u>at any time</u>, any of the following?

High Blood Pressure……...	☐	☐	_____
Diabetes……...	☐	☐	_____
Thyroid Disease……..	☐	☐	_____
Hormone Disorders…….	☐	☐	_____
Weight Gain……	☐	☐	_____
Irregular Heart Beat……	☐	☐	_____
Anxiety/Depression……	☐	☐	_____

Printed Name: _____ **Signature:** _____ **Date:** _____

For Office Use Only: **Dr. Approved Sleep Test** ☐ **Y** ☐ **N**

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Epworth Sleepiness Scale

Name: _____ **Sex:** ☐ Male ☐ Female

Date of Birth _____ **Age:** _____ **Height:** _____ **Weight:** _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
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 theatre or a 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 lunch, without alcohol ……..	_____
In a car, while stopped for a few minutes in traffic …….....	_____
Total ……	_____

Score:

0-10 Normal range
10-12 Borderline
12-24 Abnormal

Printed Name:_____ **Signature:** _____ **Date:** _____

Sleep Consultation

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Patient Name: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please **number** your complaints by severity with #1 being the most severe, #2 the second most severe and so on.

___ CPAP intolerance
___ Difficulty falling asleep
___ Fatigue
___ Frequent heavy snoring
___ Frequent heavy snoring which affects the sleep of others
___ Insomnia
___ Gasping when waking up
___ Nighttime choking spells
___ Significant daytime drowsiness
___ Sleepiness while driving
___ Witnessed apneic events
___ Morning headaches
___ Leg movements/ Restless legs
___ Teeth Grinding
___ Limited mouth opening

Other: _____

CPAP Intolerance

(Continuous Positive Airway Pressure Device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in the section below.

☐ Mask leaks
☐ Inability to get the mask to fit properly
☐ Discomfort from headgear
☐ Disturbed or interrupted sleep
☐ Claustrophobic associations
☐ CPAP does not seem to be effective
☐ Pressure on the upper lip causing tooth related problems
☐ Latex allergy
☐ Noise disturbing sleep and/or bed partner's sleep
☐ An unconscious need to remove the CPAP
☐ CPAP restricts movements during sleep
☐ Cumbersome

Other: _____

Other Therapy Attempts

☐ CPAP
☐ Weight loss
☐ Other _____
☐ Pillar procedure
☐ Smoking cessation
☐ Uvuloplasty surgery
☐ Uvulectomy surgery

History of Treatment

Practitioners Name: _____ Specialty: _____

Treatment: _____ Approximate Date: _____

Practitioners Name: _____ Specialty: _____

Treatment: _____ Approximate Date: _____

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician, as well as the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage. I certify that my medical history information is complete and accurate to the best of my knowledge.

Printed Name: _____ Signature: _____ Date: _____

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Financial Policy & Insurance

Westlake Family Dentistry

We are committed to providing you with the best possible care. If you have dental/medical insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment protocol.

Payment for treatment is due at the time services are rendered, unless payment arrangements have been approved in advance by our financial coordinator. We accept cash, checks, Visa, MasterCard, Discover, HSA/FSA cards and CareCredit. As a patient, you are fully responsible for all fees for services rendered. As a courtesy we file your insurance claims for you and accept payments directly from your insurance carrier in order to help you simplify the insurance process. If your insurance does not pay any portion of your bill you will be billed accordingly and are fully responsible for any outstanding balance. If you have secondary insurance we will be happy to bill them for you as well. **We offer a 5% discount on any amounts over $500, when paying by cash or check only, at the time of service.**

When using your dental/medical insurance benefits, please understand that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Some insurance policies restrict payment for some services. They use restricted fee schedules (called "UCR") and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, *NOT* our fees or recommended treatment. Some insurance companies arbitrarily select certain services they will not cover.

As dental care providers, we must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to all our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Returned checks are subject to a $30 charge and balances older than 30 days may be subject to interest charges of 1.5% per month or 18% per annum.

We require 48 business hours' notice for cancelations or rescheduling. Appointments canceled or rescheduled without 48 business hours' notice, and missed appointments may incur up to a $100 fee.

You will be given a printed treatment plan any time treatment is recommended, and we will gladly discuss your proposed treatment and answer any questions relating to your insurance benefits, before treatment is rendered.
If you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask us. We are here to help.

I understand that Westlake Family Dentistry will make every effort to give accurate insurance benefit estimates for my treatment, however, I am responsible for any portion not covered by my insurance company after claims have processed, as well as my estimated portion due at the time of service.

I understand that I am responsible for payment in full, at the time of treatment, if dental insurance is not applicable to my situation, unless other arrangements have been made in advance.

I have read, understand and agree to abide by the above financial policy.

Printed Name: _____ Signature: _____ Date: _____

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Westlake Family Dentistry

Acknowledgement of Receipt of Privacy Policy Notice

I, _____, have read, received and/or have been offered a copy of Westlake Family Dentistry's PRIVACY POLICY NOTICE and consent to the use of my protected health information to carry out treatment, payment activities, and healthcare operations as explained.

I understand that my information will not be disclosed in any way not outlined in the above mentioned policy, unless I have given written consent, which may be revoked at any time by me, in writing. **This includes, but is not limited to my spouse, mother, father and/or siblings.** If under age 18, information will be shared with parents and/or legal guardians.

_____

Patient Name

_____ _____

Patient Signature or Parent/Guardian Signature **Date**

<u>Patients age 18 and older</u>: please complete the following and mark what information may be shared. If there is no one you consent to share information with, please leave section blank and do not sign.

I give consent to share my information with the following parties, should they inquire:

☐ Spouse: _____ Personal: YES / NO Financial: YES / NO

☐ Mother: _____ Personal: YES / NO Financial: YES / NO

☐ Father: _____ Personal: YES / NO Financial: YES / NO

☐ Other: _____ Personal: YES / NO Financial: YES / NO

_____ _____

Patient Signature **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our PRIVACY POLICY NOTICE, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prevented obtaining this acknowledgement

☐ OTHER: _____

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Informed Patient Consent

Patient Name : _____ DOB: _____

Welcome! We would like to give you a little more information about ourselves, and what to expect during our sleep apnea testing & treatment process. This document contains important information about our professional services and business policies. Please read it carefully, and if you have any questions, we can discuss them together prior to starting the sleep apnea testing and treatment process. When you sign this document, it will represent an agreement between us.

CONFIDENTIALITY AND PRIVACY NOTICE:
Privacy is a very important concern for all those who use our services. In general, the privacy of all communications between a patient and a physician is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.
We may need to release basic diagnostic and clinical information to your insurance provider in order to obtain treatment authorization or to get claims paid. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings, a judge may order our testimony if he/she determines that the issues demand it.
There are some situations in which we are legally obligated to take action to protect you or others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency, or if we believe that a patient is threatening serious bodily harm to another. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have together. If you need specific advice, please be aware that formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.
I have read and discussed the above agreement. I understand and agree to all of the points discussed above. If at any point I have questions or problems regarding my treatment, I understand how to contact the practice, and receive support for my individual needs. I am providing consent for treatment to include, home sleep testing, diagnostic scans (such as X-ray or Cone Beam CT), and related sleep apnea treatment devices- if sleep disordered breathing is diagnosed.

Patient Signature: _____ Date: _____

Dr. Mark Gabr
Dr. Muhammad Najjar
Dr. Roukan Jazayerli
Dr. Ravi Shergill
Dr. Bradley Sievert
John Glenn PA-C

21260 S. Springwater Rd | Estacada, OR 97023

Phone: 800-279-3104 | Fax: 949-798-6979 | dentalinfo@dedicatedsleep.net | dedicatedsleep.net

Medical Records Release Form

Patient's Name: _____

Date of Birth: _____

By Signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed:

Dedicated Sleep 21260 S. Springwater Rd Estacada, OR 97023

Oregon Sleep Specialists 5331 SW Macadam Ave Portland, OR 97239

Patient Signature: _____ **Date signed**: _____