WELCOME TO OUR PRACTICE

Welcome to NCOSO where *Your beautiful smile is our passion!*

We would like to thank you for allowing us to treat you or your loved one as our patient and we are pleased to meet your oral surgery + orthodontic dental needs. We will always do our best to give you the most up-to-date and professional care available! Here is a list of our office policies and procedures:

If you or your child have active tuberculosis, persistent cough (greater than a 3-week duration, a cough that produces blood, or been exposed to anyone with tuberculosis please stop and return this form to the receptionist.

______ As a courtesy, **North Carolina Oral Surgery + Orthodontics (NCOSO)** will file your dental claim with your insurance company. Your deductible and co-pay, or any portion not covered by your insurance company, is due *at the time of service*. For those patients without insurance coverage, **you will be responsible for your payment in full on the day of treatment.**

______ **Broken appointments are very costly and inconvenient.** If you are unable to keep your appointment, please inform us at least twenty-four (24) hours in advance for orthodontic appointments and 3 business days for surgical procedures. Two or more broken appointments will lead to you and your family being dismissed from our practice. An unconfirmed appointment may run the risk of being rescheduled.

______ If you have Medicaid, **you must have your current Medicaid card with you.** Also, if you are twenty-one (21) years of age or older you are responsible for the $3.00 co-pay. If you do not have a current card, we reserve the right to reschedule your appointment.

______ If you are **more than fifteen (15) minutes late for your appointment**, you may be rescheduled for another day. This will be considered a broken appointment and could result in a $25 fee (or $100 fee for oral surgery).

______ **All patients under the age of eighteen (18) are required to have a parent or legal guardian present** with them at each appointment. They will not be seen or treated in the absence of a parent or legal guardian without a signed consent form, see page 3.

______ In the event your payment is past due, **you are responsible to pay the cost of collecting any debt owed on your account**. This includes all attorney's fees, late fees, and interest to be charged at one percent per month.

_____ I've been given the opportunity to read the **Notice of Privacy Practices**.

Your cooperation is greatly appreciated in this matter. If you have any questions, please feel free to ask our staff and as always thank you for choosing NCOSO!

______________________________________ ______________________

Signature of Patient or Responsible Party Date

(**Office Only:** We were unable to obtain written acknowledgement of receipt of Privacy Practices because:

☐ An emergency existed, and a signature was not possible at the time. ☐ The individual refused to sign.

☐ A copy was mailed with a request for a signature. ☐Other: ____________________

Name: ____________________ Signature: ______________________________ Date: ____________

Name of Patient: ______________________________ **Date of Birth:** ____________________

NC Oral Surgery + Orthodontics is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. Patient Signature: ______________________

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other______________________
☐ Spouse (provide name & phone number) ______________________	☐ Financial ☐ Medical as follows: ______________________
☐ Parent (provide name & phone number) ______________________	☐ Financial ☐ Medical as follows: ______________________
☐ Other (provide name & phone number) ______________________	☐ Financial ☐ Medical as follows ______________________

How did you select NC Oral Surgery + Orthodontics (NCOSO)?

Please select the option that applies:

☐ Family Member/Friend Referral
☐ Dentist Referral
☐ Accepts My Insurance
☐ Inter-Office Transfer
☐ NCOSO.com (website)
☐ Google Search
☐ Yahoo! Search
☐ Bing Search
☐ YP.com
☐ Google Maps
☐ Newspaper/Magazine
☐ Phone Book
☐ Open House
☐ Mail Flyer
☐ Office Appearance/Exterior
☐ Fair/Festival – Which one? ____________

Patient Information & Medical History

ORAL SURGERY + ORTHODONTICS

Your beautiful smile is our passion!

Patient Information

Name of Child: Last First MI | Date of Birth:

Address: | City: | State: | Zip:

Social Security Number: | Sex: | Age: | Race: | Weight:

Mother's/Guardian Name: | Social Security Number:

Address: | City: | State: | Zip:

Primary Phone Number: | Secondary Phone Number: | Email:

Father's/Guardian Name: | Social Security Number:

Address: | City: | State: | Zip:

Primary Phone Number: | Secondary Phone Number: | Email:

Responsible Party

Name: *Last* *First* *MI* | Relationship: | Phone: ( )

Address: | City: | State: | Zip:

Date of Birth: | Employer: | Social Security: | Driver's License Number:

Circle Method of Payment: Cash Visa/MC Check Insurance Other

Insurance

Name of Insured: | Date of Birth: | Relationship to Patient: | Social Security:

Employer: | Insurance Company:

Address: *City* *Zip* | Phone: ( )

Group Number: | Policy Number:

If you have additional dental insurance, please notify our staff.

Dental Insurance

As a courtesy, we will be happy to file your insurance claims as well as obtain all plan information and provisions. It is our pleasure to assist you with this; however, we encourage you to become familiar with your coverage and benefit period allowances. We strive to assist you in utilizing and maximizing your coverage and recommend that you also maintain knowledge of your benefits used throughout the benefit period.

Please understand that your insurance is a contract between you, your employer, and your insurance company. Thus, we cannot speak on behalf of your insurance company. We will gladly act as your advocate, but we cannot be responsible for settling any disputed claims or coverage. We thank you for choosing us to provide excellent dental care for you, and we look forward to taking care of your dental needs.

If we do not receive payment from your insurance carrier **within forty-five (45) days,** we will notify you. Failure of your insurance carrier to reimburse our office **within sixty (60) days** will result in our billing you directly for the remaining balance. **Please remember that you are ultimately responsible for your bill.**

Signature of Patient or Responsible Party ______________________ Date __________

Health History: Please answer the following questions in regard to your child.

Has the child had any history of, or conditions related to, any of the following:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV + / AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (Teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex Allergy	☐ Rheumatic Fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle cell	☐

Child's Physician Name: | Phone: ( )

Medical Information

(Check DK if you Don't Know the answer to the question)

Question	Yes	No	DK
Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?	☐	☐	☐
If yes, please list: ______			
Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ______	☐	☐	☐
Is the child allergic to anything else, such as certain foods? If yes, please explain: ______	☐	☐	☐
How would you describe the child's eating habits? ______			
Has the child ever had a serious illness? If yes, when: ______ Please describe: ______	☐	☐	☐
Has the child ever been hospitalized?	☐	☐	☐
Does the child have a history of any illnesses? If yes, please list: ______	☐	☐	☐
Has the child ever received a general anesthetic?	☐	☐	☐
Does the child have any inherited problems?	☐	☐	☐
Does the child have any speech difficulties?	☐	☐	☐
Has the child ever had a blood transfusion?	☐	☐	☐
Is the child physically, mentally, or emotionally impaired?	☐	☐	☐
Does the child experience excessive bleeding when cut?	☐	☐	☐
Is the child currently being treated for any illnesses?	☐	☐	☐
Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ______	☐	☐	☐
Has the child had any problem with dental treatment in the past?	☐	☐	☐
Has the child ever had dental radiographs (x-rays) exposed?	☐	☐	☐
Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐	☐
Has the child had any problems with the eruption or shedding of teeth?	☐	☐	☐
Has the child had any orthodontic treatment?	☐	☐	☐
What type of water does your child drink? ☐ City Water ☐ Well Water ☐ Bottled Water ☐ Filtered Water			
Does the child take fluoride supplements?	☐	☐	☐
Is fluoride toothpaste used?	☐	☐	☐
How many times are the child's teeth brushed per day? ______ When are the teeth brushed? ______	☐	☐	☐
Does the child such his/her thumb, fingers or pacifier?	☐	☐	☐
At what age did the child stop bottle feeding? Age ______ Breast Feeding? Age ______			
Does the child participate in active recreational activities?	☐	☐	☐

Parental Consent

I request and authorize NC Oral Surgery + Orthodontics to perform the treatment and procedures outlined on treatment plan for:

____

I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable by the clinical faculty to diagnose and/or treat the patient's dental needs.

- I have had explained to me, and I have had sufficient opportunity to discuss the patient's dental condition and needs, the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.
- The usual and most frequently occurring risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain and/or discomfort during the following treatment swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint (TMJ) disorder, temporary or permanent numbness, and allergic reactions.
- I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to, or different from those listed on the patient's treatment plan and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient will receive.
- I understand that at North Carolina Oral Surgery + Orthodontics that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. We will provide a clinical environment that is likely to help children to learn to cooperate during treatment. To accomplish this, the patient's behavior will be guided using praise, explanation, and demonstration of procedures and instruments, using variable voice tone and loudness.
- I understand that should the patient become uncooperative during dental procedures with movement of the head, arms, and/or legs, dental treatment cannot safely be provided. During such disruptive behavior, it may be necessary for the assistant to hold the patient's hands, stabilize the head, and/or control leg movements. If we still cannot provide treatment, we will reschedule the patient.
- All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the treatment plan.
- I understand that I may revoke this consent, in writing at any time, and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
- I confirm that I have read and understand this form, or it was read to me, and that all blanks were filled and all inapplicable paragraphs, if any, were stricken prior to my signing below.
- If anyone other than yourself, legal guardian, is allowed to bring your child to their dental visit please list name & relationship:

______________________ Name

______________________ Relationship to Patient

______________________ Signature of parent, legal guardian, or care taker

______________________ Date

______________________ Printed Name

______________________ Date

______________________ Witness

______________________ Date

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

____ ____________________
Signature of Patient/Legal Guardian Date

____ ____________________
Signature of Dentist Date

Sleep Screening Questionnaire

Please answer the questions below to help us assess the possibility of a sleep disorder which may be related to your dental and overall health. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke. If you are here with your child (under 16), please fill out the lower portion marked "For children only" for your child.

Name:______________________________ **Height:**____________ **Weight:**____________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze
1 = I have a slight chance of dozing
2 = I have a moderate chance of dozing
3 = I have a high chance of dozing

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

Have you ever been diagnosed with:	**Yes**	**No**
1. Impaired Cognition (i.e. difficulty concentrating or thinking)	☐	☐
2. Mood Disorders/Depression	☐	☐
3. Insomnia	☐	☐
4. Hypertension (high blood pressure)	☐	☐
5. Ischemic Heart Disease (Coronary Artery Disease/Atherosclerosis)	☐	☐
6. History of Stroke	☐	☐
7. Sleep Apnea	☐	☐
If yes: Did you try to use CPAP	☐	☐
8. TMJ problems significant enough to require treatment	☐	☐
9. Gastric Reflux (GERD) or Heartburn	☐	☐

Are you aware of (or have you been told):	**Yes**	**No**
1. Snoring on a regular basis	☐	☐
2. Feeling tired or fatigued on a regular basis	☐	☐
3. Clenching or grinding your teeth (bruxism)	☐	☐
4. Having frequent headaches	☐	☐
5. Your neck size being > 17 inches (male) or > 16 inches (female)	☐	☐
6. Anyone in your family having sleep apnea	☐	☐
7. Stopping breathing when sleeping/awakening with a gasp	☐	☐

For children only (filled out by parent or guardian)

Are you aware of your child:	**Yes**	**No**
1. Snoring/noisy breathing while sleeping	☐	☐
2. Grinding his or her teeth	☐	☐
3. Wetting the bed	☐	☐
4. Having difficulty in school/learning	☐	☐
5. Being treated for ADD or ADHD	☐	☐
6. Breathing primarily through their mouth	☐	☐
7. Having frequent nightmares/night terrors	☐	☐
8. Having frequent ear aches	☐	☐

DENTIST'S EXAM FINDINGS AND SIGNATURE:

☐ **Evidence of Bruxism** ☐ **Scalloping of the tongue** ☐ **Crowded airway** ☐ **Tori or Bone Loss** ☐ **Anterior wear**
☐ **Occlusal Wear** ☐ **Macroglossia** ☐ **Restricted Arch** ☐ **Retrognathia / Class II** ☐ **Mallampati** __________

____ ____________________
Dentist Signature Date