ORAL SURGERY + ORTHODONTICS

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 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.

_____ initial 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.**

_____ initial **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.

_____ initial 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.

_____ initial 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).

_____ initial **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. Please ask our front desk for more information or to request a form.

_____ initial 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.

By signing below, you also agree that you have read and understood our **Notice of Privacy Practices**. A copy of this agreement is available upon request.

_____ 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: _____

Employee: _____ Signature: _____ Date: _____

Authorization for Release of Information

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
☐ Yelp Search
☐ Bing Search
☐ Phone Book
☐ Google Maps
☐ Newspaper/Magazine
☐ Mail Flyer
☐ Open House
☐ Social Media – Which one? _____
☐ Office Appearance/Exterior
☐ Fair/Festival – Which one? _____

Patient Information & Medical History

ORAL SURGERY + ORTHODONTICS

Your beautiful smile is our passion!

Patient Information

Name: *Last* *First* *MI* | Home Phone: ( ) | Business/Cell Phone: ( )

Address: | City: | State: | Zip:

Email: | Social Security: | Driver's License Number:

Employer: | Occupation: | Sex: M F | Age: | Height: | Weight:

Emergency Contact: | Relationship: | Home Phone: | Cell Phone:

Responsible Party: ☐Check here if same as above.

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

Address: | City: | State: | Zip:

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

Insurance

Name of Insured: *Last* *First* *MI* | Date of Birth: | Relationship to Patient:

Employer: | Insurance Company: | Social Security:

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

Smile Report

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: **DAILY/WEEKLY/OCCASIONALLY**			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

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

Are you now under the care of a physician? Yes ☐ No ☐ DK ☐
Physician Name: Phone: ( )
Address/City/State/Zip:

Are you in good health? Yes ☐ No ☐ DK ☐
Has there been any change in your general health within the past year? Yes ☐ No ☐ DK ☐
If yes, what condition is being treated? _____

Date of last physical exam:

Do you wear contact lenses? Yes ☐ No ☐ DK ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ☐ No ☐ DK ☐
Date: _____
If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? Yes ☐ No ☐ DK ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes ☐ No ☐ DK ☐
Date Treatment began: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes ☐ No ☐ DK ☐
If yes, what was the illness or problem? _____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes ☐ No ☐ DK ☐
If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: _____

Are you currently using any recreational drugs? (cocaine, cannabis, etc.) Yes ☐ No ☐ DK ☐

Do you use controlled substances (drugs)? Yes ☐ No ☐ DK ☐

Do you use tobacco (smoking, snuff, chew, bidis)? Yes ☐ No ☐ DK ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESETED

Do you drink alcoholic beverages? Yes ☐ No ☐ DK ☐
If yes, how much alcohol did you drink in the last 24 hours? _____
If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:
Pregnant? Yes ☐ No ☐ DK ☐
Number of weeks _____
Taking birth control pills or hormonal replacement? Yes ☐ No ☐ DK ☐
Nursing? Yes ☐ No ☐ DK ☐

Allergies. Are you allergic to or have you had a reaction to:

To all yes responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

	Yes	No	DK
Angina	☐	☐	☐
Congestive heart failure	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Damaged heart valves	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Stroke	☐	☐	☐
Hemophilia	☐	☐	☐
Arthritis	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
Heart Attack	☐	☐	☐
Heart Murmur	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Chronic Pain	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Abnormal bleeding	☐	☐	☐
Ulcers	☐	☐	☐
STD	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus Trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Thyroid problems	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Migraines	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Night Sweats	☐	☐	☐
Mental Health disorders	☐	☐	☐
If yes, specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Excessive urination	☐	☐	☐
Eating Disorder	☐	☐	☐
Malnutrition	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? YES / NO
Name of physician or dentist making recommendation: Phone: ( )

Do you have any disease, condition, or problem not listed above that you think we should know about?
Please explain:

Would you consent to a blood test (at our expense) if the Doctor or Staff member suffers a needle stick or puncture wound? YES / NO

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

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	☐	☐

	Do you suffer from any of the following conditions?	**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 age 16 and under (filled out by parent or guardian)

	Does your child suffer from any of the following?	**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