WHOLE TREE DENTISTRY
SLEEP & BREATHING WELLNESS

Thank you for choosing our practice. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION

DATE _____

PATIENT'S NAME _____ DOB _____

SOCIAL SECURITY # _____ SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: _____

ADDRESS _____ CITY/ST/ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DRIVER'S LICENSE #: _____ STATE: _____ E-MAIL ADDRESS _____

PHARMACY NAME: _____ PHARMACY PHONE #: _____

EMPLOYER: _____ EMPLOYER ADDRESS: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

OTHER FAMILY MEMBERS SEEN BY US: _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

NAME _____ RELATIONSHIP TO PT: _____

ADDRESS _____ CITY/ST/ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SOCIAL SECURITY # _____ DOB _____ SEX: ☐ MALE ☐ FEMALE

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT INFORMATION

NAME _____ PHONE _____ RELATIONSHIP _____

INSURANCE INFORMATION - PRIMARY

INSURANCE COMPANY NAME _____

EMPLOYER OF POLICY HOLDER _____

POLICY OWNER'S NAME _____ RELATIONSHIP TO PATIENT: _____

INSURANCE CLAIM ADDRESS: _____

INSURANCE CLAIM PHONE # _____ INSURANCE ID# _____ GROUP # _____

GROUP # _____ PHONE# _____

ASSIGNMENT OF BENEFITS: I assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, Private Insurance and any other health plan to Whole Tree Dentistry. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges and I authorize said assignee to release all information necessary to secure payment.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

SIGNED: _____ DATE: _____

WHOLE TREE DENTISTRY
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ADULT NEW PATIENT REGISTRATION & MEDICAL BACKGROUND INFORMATION

PATIENT INFORMATION

PATIENT'S NAME _____ DOB_____

CHIEF COMPLAINT: _____

SLEEP HISTORY

LIGHTS OUT: _____ ☐AM ☐PM LIGHTS ON: _____ ☐AM ☐PM

Number of awakenings during the night: _____ Trips to the bathroom during the night: _____

Do you take any sleep aids to help you sleep? ☐Yes ☐No If yes, what kind? _____

MEDICATIONS (including prescription and over-the-counter)

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____
4. _____ 8._____

Do you have a history of any of the following? *(Check if "YES" to any of the following)*

- ☐ Difficulty falling asleep at night
- ☐ Snoring
- ☐ Witnessed apneas
- ☐ Gasping/choking during sleep
- ☐ Sweating/perspiring in sleep
- ☐ Drooling in sleep
- ☐ Dry mouth upon awakening
- ☐ Teeth grinding/clenching
- ☐ Heart palpitations
- ☐ GERD/reflux/heartburn
- ☐ Excessive daytime sleepiness
- ☐ Tired/fatigued during the daytime
- ☐ Nasal allergies/hay fever/nasal congestion
- ☐ Asthma
- ☐ TMJ pain/jaw discomfort
- ☐ Erectile dysfunction
- ☐ Decreased libido
- ☐ Hypertension/high blood pressure
- ☐ Depressed mood/irritability
- ☐ Anxiety/stressed out
- ☐ Difficulty with concentration
- ☐ Memory problems
- ☐ Cold hands/feet
- ☐ Chest pain/chest discomfort
- ☐ Shortness of breath during the day
- ☐ Acting out dreams
- ☐ Morning headaches
- ☐ Difficulty staying asleep
- ☐ Excessive movements in sleep
- ☐ Nightmares/bad dreams
- ☐ Sleep walking/sleep talking

PAST MEDICAL HISTORY

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____
4. _____ 8._____

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ADULT NEW PATIENT REGISTRATION & MEDICAL BACKGROUND INFORMATION (CONT'D)

PAST SURGICAL HISTORY

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Have you ever had your tonsils and/or adenoids surgically removed? ☐ Yes ☐ No

ALLERGY HISTORY

☐ None Known ☐ YES, to:

1. _____ 3. _____
2. _____ 4. _____

SOCIAL HISTORY

Caffeine:
_____ # of cups of coffee per day
_____ # of cups of tea per day
_____ # cans or glasses of soda per day
_____ # of servings of chocolate per week
_____ # of energy drinks per day

Alcohol: ☐ None ☐ Yes _____ # of drinks per day _____ # of drinks per week _____ # of drinks per month

Tobacco: ☐ None ☐ Yes _____ # of packs per day _____ # of years

Recreational Drugs (such as marijuana or cocaine): ☐ None ☐ Yes
If yes, which ones? _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children: ☐ Yes ☐ No How many? _____

Pets: ☐ Yes ☐ No How many? _____ What type of pet? _____

Do you have any children or pets that sleep in your bedroom? ☐ No ☐ Yes _____

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? *(Check if "YES" to any of the following)*

- ☐ High blood pressure/hypertension
- ☐ Heart disease
- ☐ Stroke
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Diabetes
- ☐ Overweight/obesity
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Anxiety
- ☐ Chronic insomnia
- ☐ Restless legs syndrome
- ☐ Multiple sclerosis
- ☐ Sleep walking

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REVIEW OF SYMPTOMS

CONSTITUTIONAL:
- Loss of appetite: ☐ Yes ☐ No
- Sweats: ☐ Yes ☐ No
- Fever: ☐ Yes ☐ No
- Fatigue: ☐ Yes ☐ No
- Weight Gain: ☐ Yes ☐ No
- Weight Loss: ☐ Yes ☐ No

GASTROINTESTINAL:
- Heartburn/Indigestion: ☐ Yes ☐ No
- Black or Bloody Stools: ☐ Yes ☐ No
- Diarrhea: ☐ Yes ☐ No
- Nausea/Vomiting: ☐ Yes ☐ No
- Jaundice: ☐ Yes ☐ No
- Abdominal Pain: ☐ Yes ☐ No

ALLERGY/IMMUNOLOGY:
- Sneezing: ☐ Yes ☐ No
- Runny Nose: ☐ Yes ☐ No
- Itchy Eyes or Nose: ☐ Yes ☐ No
- Hives: ☐ Yes ☐ No

EYES:
- Blurry Vision: ☐ Yes ☐ No
- Double Vision: ☐ Yes ☐ No
- Vision Loss: ☐ Yes ☐ No

CARDIAC:
- Palpitations: ☐ Yes ☐ No
- Chest Pain: ☐ Yes ☐ No
- Daytime Shortness of Breath: ☐ Yes ☐ No
- Nighttime Shortness of Breath: ☐ Yes ☐ No
- Ankle Swelling: ☐ Yes ☐ No

SKIN:
- Unusual Moles: ☐ Yes ☐ No
- Rash: ☐ Yes ☐ No
- Dryness: ☐ Yes ☐ No

ENDOCRINE:
- Weight Gain: ☐ Yes ☐ No
- Heat Intolerance: ☐ Yes ☐ No
- Excessive Thirst: ☐ Yes ☐ No
- Constipation: ☐ Yes ☐ No
- Cold Intolerance: ☐ Yes ☐ No

RESPIRATORY:
- Cough: ☐ Yes ☐ No
- Shortness of breath: ☐ Yes ☐ No
- Wheezing: ☐ Yes ☐ No
- Poor Exercise Tolerance: ☐ Yes ☐ No

GENITOURINARY:
- Bed Wetting: ☐ Yes ☐ No
- Frequent Urination: ☐ Yes ☐ No
- Difficulty Urinating: ☐ Yes ☐ No
- Blood in Urine: ☐ Yes ☐ No

MUSCULOSKELETAL:
- Stiff/Sore Joints: ☐ Yes ☐ No
- Muscle Pain: ☐ Yes ☐ No
- Red or Swollen Joints: ☐ Yes ☐ No

EARS/NOSE/THROAT/MOUTH:
- Hearing Loss: ☐ Yes ☐ No
- Sore Throat: ☐ Yes ☐ No
- Sinus Congestion: ☐ Yes ☐ No
- Hoarseness: ☐ Yes ☐ No

NEUROLOGIC:
- Weakness: ☐ Yes ☐ No
- Seizures: ☐ Yes ☐ No
- Involuntary Tongue Biting: ☐ Yes ☐ No
- Passing Out: ☐ Yes ☐ No
- Dizziness: ☐ Yes ☐ No
- Headaches: ☐ Yes ☐ No
- Numbness: ☐ Yes ☐ No

HEMA/LYMPH:
- Unexplained Weight Loss: ☐ Yes ☐ No
- Unusual Bleeding/Bruising: ☐ Yes ☐ No
- Swollen Lymph Nodes: ☐ Yes ☐ No

PSYCH:
- Excess Stress: ☐ Yes ☐ No
- Memory Loss: ☐ Yes ☐ No
- Difficulty with Focus: ☐ Yes ☐ No
- Trouble Concentrating: ☐ Yes ☐ No
- Hallucinations: ☐ Yes ☐ No
- Nervousness or Anxiety: ☐ Yes ☐ No

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes hoe medical information about you may be used and dsiclosed and how you can get access to this information.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information (PHI) may be used and disclosed by your dentist, office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare with any related health services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a durable medical equipment company that provides care to you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessay information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services; For example, obtaining approval for an overnight sleep study may require that your relevant protectd health information be disclosed to obtain approval or authorization.

Healthcare Operations: We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may also call you by name in the waiting room when your doctor is ready to see you.

We may use or disclose your PHI in the following situations without your authorization. These situations include, as required by law, public health issues as required by law, communicable diseases, abuse or neglect, FDA requirements, legal proceedings, law enforcements, coroners, criminal activities, military activities and national security, and worker's compensation. Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization at any time, in writing, except to the extent that your physician's practice has taken action in reliance on the use of disclosure indicated in the authorization.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice Of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

_____

Date

WHOLE TREE DENTISTRY
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MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

NAME: _____ DATE OF BIRTH: _____

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____
- ☐ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call:
- ☐ My Home _____
- ☐ My Work _____
- ☐ My Cell _____
- ☐ Other _____

If unable to reach me:

- ☐ You may leave a detailed mesage
- ☐ Please leave a message asking me to return your call
- ☐ Other _____

The best time to reach me is (day) _____ between (time) _____.

_____ _____

Signature Date