

Name _____ SS# _____
Last First Middle

Preferred Name _____ Date of Birth _____ Male Female Marital Status _____

Address _____

City/State/Zip _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

May we call you at your work number? _____

Who may we thank for referring you to our office? _____

How did you hear of our office? Website Newspaper Magazine Outside Sign Physician Yellow Pages
 Other _____

Spouse/Responsible Party information

Name _____ SS# _____

Address _____ City/State/Zip _____

Phone _____ Email _____ Date of Birth _____

Employer _____ Occupation _____

Method of payment or co-payment: Cash Check Visa MasterCard Discover Care Credit or other finance company

Insured's Name _____ Insured's Employer _____ Date of Birth _____

Dental Insurance Company _____ Address _____

Group _____ Policy # _____ ID# _____

In an emergency, who should be notified? Name _____ Phone Number _____

I certify that I have completed this form fully and completely. The above information is accurate to the best of my knowledge and I understand that providing false information can be dangerous to my health. I grant authority to the Dentist and staff to perform the necessary exam, x-rays, and subsequent treatment needed to restore and maintain my dental health or the health of my dependent.

I authorize and request my insurance company to pay benefits on my behalf directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, including any collection costs.

Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____	<input type="checkbox"/>	<input type="checkbox"/>	28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa			33. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			37. STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			38. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	43. emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	45. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol / recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy / sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	56. taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	57. currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	58. prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
 (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
 Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____
6. Have you had any teeth removed or missing teeth that never developed? _____

GUM AND BONE



7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____

TOOTH STRUCTURE



14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT



21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench your teeth in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS



33. Is there anything about the appearance of your teeth that you would like to change? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operation.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Tracy Davis or Dr. Nick Matthews

Telephone: (417) 581-3600 Fax (417) 581-8899

Address: 1427 W. State Highway J, Ozark, MO 65721

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Sleep Health Questionnaire

Date _____

M F

Name _____ Gender _____ DOB _____

Address, City, State, Zip _____ Weight _____ Height _____

Cell Phone _____ Alt. Phone _____ Email _____

Medical Insurance Company _____ ID# _____ Group# _____

Section 1 - Patient Sleepiness Scale:

Step 1: Answer "Yes" or "No" for the following questions (circle Y or N). If you answer "yes" also circle the corresponding points in the column to the right.

Step 2: Total the points that you circled in the right column and record score in the space below.

Have you ever been told you stop breathing while asleep?	Y or N	8
Have you ever fallen asleep or nodded off while driving?	Y or N	6
Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y or N	6
Do you feel excessively sleepy during the day?	Y or N	4
Do you snore or have you ever been told that you snore?	Y or N	4
Have you had weight gain and found it difficult to lose?	Y or N	2
Have you taken medication for, or been diagnosed with high blood pressure?	Y or N	2
Do you kick or jerk your legs while sleeping?	Y or N	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y or N	3
Do you wake up with headaches during the night or in the morning?	Y or N	3
Do you have trouble falling asleep?	Y or N	4
Do you have trouble staying asleep once you fall asleep?	Y or N	4
Score		

Risk Level	Low	Moderate	High	Severe
Score	0-7	8-11	12-15	16+

Section 2 - Signs & Symptoms (Check all that apply):

- Hypertension Snoring Diabetes
 Depression Grind Teeth Acid Reflux
 Stroke/Heart Disease Unrefreshed Sleep
 Family history of Snoring or Sleep Apnea

Section 3 - Sleep History (Check all that apply):

- Have you ever been diagnosed with a sleep disorder? Yes No
 Are you currently using a CPAP machine? Yes No
 Do you use your CPAP less than 5 times a week? Yes No
 Would you prefer an oral appliance? Yes No

Please Present Completed Form, ID & Medical Insurance Card to Front Desk to Allow for Copies

Fax: 888-793-3903

Email: orderentry@ezsleeptest.com

Phone: 888-240-7735

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SHQ Prescription Form

Patient Name _____

Date of Birth _____

Sleep Apnea Management & Risk Assessment Exam: (SAM Exam)

Signs & Symptoms:

- Hypertension Loud Snoring Depression GERD
- Bruxism Diabetes Narrow or V-shaped upper arch
- Soft tissue that visually impairs airway Witnessed choking or gasping for breath
- Large or scalloped tongue Neck Size (Male) ≥ 17" or Neck Size (Female) ≥ 16"

Referral Assessment: Consider sleep testing if 1 (or more) boxes below are checked

- Section 1: PSS Score ≥ 08 (Moderate - Severe)
- Section 2: 2 (or more) Signs & Symptoms indicated
- Section 3: "Yes" to 3 (or more) of Sleep History questions

Rx: Baseline home sleep study G47.33 to be used to rule out OSA, unless stated differently. If other, please specify: _____
 Two-night Home Sleep Study or _____-night (Indicate number of nights 1-3)

 Two-night Efficacy Test w/ Oral Appliance or _____-night (Indicate number of nights 1-3)
 Two-night Efficacy Test w/ Apnea Guard or _____-night (Indicate number of nights 1-3) **L M H**

Patient Data / Vital Signs:
 Height _____ Weight _____ Neck _____
 BP _____ Heart Rate _____ BMI _____

Group/Practice Name		Doctor's Name	
Address, City, State, Zip		Sleep Study Report Delivery Preference:	Email Fax
Phone		Email or Fax #	
State License #	NPI #	Office Contact & Title	Account Code
Special Notes			
Dr. Signature		Date	
I certify that above home sleep test is medically indicated and is reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.			

(Patient to fill out and sign below if sleep test is prescribed)

Consent to Coordinated Care

Sleep disordered breathing (snoring and sleep apnea) can affect a number of systems in the body. Our practice would like to communicate with your doctors about your condition and your treatment progress in order to achieve the best outcome possible. Please provide the names and contact information for your health care team below:

Family Doctor

Other Doctor

Name			Name		
Phone			Phone		
Fax			Fax		
Address					
City		State		Zip	
City		State		Zip	

Release of Information

By signing below, I authorize the practice listed above to release any medical information (i.e. exam findings, diagnosis, treatment programs, etc.) that is requested by:

- My primary care physician, dentist and other health care providers.
- Ez Sleep, diagnostic in-home testing provider.
- Insurance companies or other organizations or entities as may be required by said representatives for payment of claims for services provided by our practice.

Patient Signature _____

Date _____

Fax or email Completed SHQ Forms Page 1 & 2 and include copies of ID & Medical Insurance Cards

Fax: 888-793-3903

Email: orderentry@ezsleeptest.com

Cell: 818-335-6598

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Office: 888-240-7735



Tracy D Davis, DDS • Nick Matthews, DDS
1427 W State Hwy J • Ozark, MO 65721 • (417) 581-3600
www.exceldental.com

EXCEL DENTAL INSURANCE POLICY

- (1) Dental insurance is a contract between the insured (patient) and the insurance company designated by the patient's employer. Excel Dental is NOT a part of this contract.
- (2) The insured (patient) is ultimately responsible for informing Excel Dental of ANY change in their insurance policy. This includes, but is not limited to, changes in insurance companies, changes in insurance policy, employment status, calendar year dates, and dollar maximums.
- (3) Excel Dental will ASSIST the insured (patient) in filing their insurance claim, but we are only doing this as a COURTESY to the patient. The patient is ultimately responsible for providing the payment for dental services.
- (4) Excel Dental will estimate the insured's dental benefits, but this is ONLY an ESTIMATE. Our office has no control over the insurance company and the actual benefits available to the insured. Again, this is a contract between the insurance company, the employer, and the insured. Excel Dental is not a part of this contract.
- (5) The insured (patient) is responsible for any portion of the dental fee not covered by insurance. I understand that my portion due will be paid in cash, check, credit card, or I may apply for credit through a Finance Company.
- (6) Excel Dental does not provide in-office financing, therefore the balance needs to be paid at the time of service. If you do not comply, you will also be responsible to pay all collection agency fees, attorney fees, and any other legal costs to collect any unpaid balances.
- (7) Please remember that the estimation of your out of pocket expense and the filing of your insurance claim is done strictly as a courtesy. This courtesy may be revoked at anytime. If so, you will be responsible for the full payment of your dental bill at the date of service. An itemized receipt will be given to you so that you may file your own claim.