Pointe Dental Sleep Medicine
TREATMENT OF SNORING AND SLEEP APNEA

Pointe Dental Group

Pointe Orthodontics & Periodontics

Section I: **Patient Information** **Date**_____

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_____ City/State_____ ☐ FT ☐ PT

Spouse or Parent's Name:_____ Employer_____ Work Phone_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (_____)_____
Employer_____ Work Phone (____)_____ SSN#_____
Driver License#_____

Insurance Information

---------- **PRIMARY INSURANCE**----------
Name of Insured_____DOB_____Relationship to Patient _____

SSN#:_____ Name of Employer:_____ Work Phone: (_____)_____

Address of Employer:_____City_____State:_____Zip _____

Insurance Company_____ Grp #_____ ID#_____

Ins Co Address:_____ Ins Co. Phone:_____

---------- **SECONDARY INSURANCE**? ☐ Yes ☐ No IF **YES**, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (_____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

For Insurance Assignment:

I AUTHORIZE RELEASE ON *ANY* INFORMATION RELATING TO THIS OR FUTURE DENTAL CLAIMS, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____ _____
SIGNED (PATIENT, OR PARENT IF MINOR) DATE

We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist in estimating your portion of the cost of treatment, we at no time guarantee what your insurance will/will not do with each claim. It's your responsibility to know the details of your dental plan. The plan is a contract between you and your insurance, not the insurance and the office. **MOST IMPORTANTLY**, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you been a patient in the hospital during the past two years? ..... YES NO
4. Have you been under the care of a physician during the past two years? ..... YES NO
   For _____
   Physician's Name _____ Phone #_____
5. Have you taken any medicine or drugs during the past two years? ..... YES NO
   If yes, please list: _____
6. Are you aware of being allergic to any medications or substance? ..... YES NO
   If yes, please list:_____
7. Circle any previous or present condition:

A. AIDS/HIV	I. Heart Problem	P. Rheumatic Fever
B. Arthritis	J. Hepatitis	Q. Stroke
C. Asthma	K. High Blood Pressure	R. Thyroid Disease
D. Epilepsy	L. Artificial Joints	S. Special Needs
E. Cancer	M. Kidney Problems	T. Other Diseases
F. Diabetes	N. Low Blood Pressure	
G. Glaucoma	O. Nervous Breakdown	
H. Blood Thinners	or Psychiatric Therapy	

If you circled either I, S or T describe condition:
_____
_____

8. Have you, or are you currently taking **Fosamax, Fosamax+D, Actonel, Actonel+Ca, Skelid, Didronel, Boniva, Reclast, Aredia, Zometa or any other bisphonshonate** medication (osteoporosis or cancer treatment medication)? ..... YES NO
9. Has your medical doctor ever told you, you have a cancer or tumor?..... YES NO
10. Have you ever had a skin rash or other reaction to metal jewelry? To what? _____ YES NO
11. Do you take or have been told you need to take premedication before dental treatment?..... YES NO

FOR WOMEN ONLY:
Are you pregnant? YES/NO If yes, what month? _____ Are you taking birth control pills? YES /NO

THE ABOVE INFORMATION IS TRUE AND ACKNOWLEDGE RECEIPT OF PRIVACY PRACTICES NOTICE

Patient Signature:_____ Date _____/_____/_____

CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that 1 ½ % finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest in the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature:_____ Date ___/____/_____ Witness _____

Parent or Responsible Party _____Relationship to Patient_____