HUNTLINE DENTAL GROUP

Patient Registration

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ○ Male ○ Female Employment Status: ○ Full Time ○ Part Time ○ Retired

Birth Date: _____ Soc Sec: _____ Email: _____

Marital Status (Circle One): Married Single Divorced Separated Widowed

Referred by: _____ Previous Dentist: _____

Responsible Party (If someone other than the patient fill out)

First Name: _____ Middle Initial: _____ Last Name : _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Soc Sec: _____ Email: _____

Primary Insurance Information

Name of Insured: _____

Insured Birth Date: _____

Insured Soc. Sec: _____

Employer: _____

Relationship to Insured: _____

Ins Company: _____

Secondary Insurance Information

Name of Insured: _____

Insured Birth Date: _____

Insured Soc. Sec: _____

Employer: _____

Relationship to Insured: _____

Ins Company: _____

Individuals that we are authorized to Speak to About your Care

Emergency Contact: _____ Phone: _____ Relationship: _____

Signature: _____ Date: _____

Huntline Dental Group

Eaglesoft Medical History

Date 10/18/2018

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Patient Acknowledgement of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me.

_____ _____

Patient's Signature Date

_____

Print Legal Guardian's Name (if patient is a minor)

_____

Legal Guardian's Signature

- For office use only:

☐Patient refused a copy of the Notice of Privacy Practices (NPPs).
☐Patient refused to sign Acknowledgement of NPPs.

_____ _____

Print Name (office staff) Date

_____

Signature

HUNTLINE
DENTAL GROUP

Office Policy

Office policies and fees for services provided are determined by Dr. Sam Barnhart only. Insurance companies make their own decisions on which procedures and how much they will pay for each. The doctor has no control or participation with any insurance company or policy except Delta Dental Premier. We will file your dental insurance for you. It is your responsibility to make sure they pay on your claim. Dr. Sam provides insurance companies with pre-operative x-rays, photos, and in some cases written narratives, to help ensure proper coverage by your insurance, but if for some reason your insurance company denies your claim, you are fully responsible for any remaining balance you may have accrued above and beyond your expected co-pay that you have already paid. You are financially responsible for any difference in billed amount and payment from insurance. In the event that your insurance checks are inadvertently sent to you, you may pay the office directly for the insurance payments you received. **Payment and or Insurance Co-payments are due prior to scheduling any treatment visits**, to include the office visit and the anticipation out-of-pocket cost for your specified procedure. Methods of payment include cash, credit card or check. In the event that your insurance company does not pay for any reason you are responsible for the bill in full. It is your job as a patient to know and understand your insurance plan policies.

Cancellation Policy

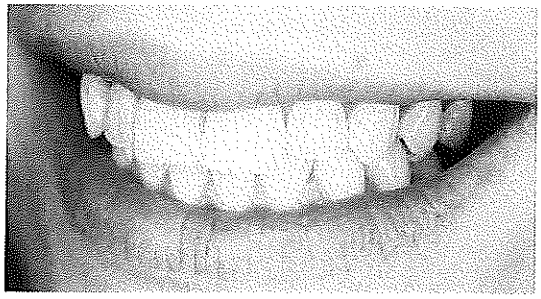
We understand emergencies do occur and it may be impossible for you to make all appointments. However, we do expect to be notified within **48 hours** in advance if you will not be able to make a scheduled appointment. In the event that you miss your appointment without notifying us in advance, a note will be made in your chart. Once you miss two appointments without prior notification, we reserve the right to discontinue your appointments. We ask that you respect our time, and we will respect yours.

In-Office Photography

Huntline Dental Group uses patient intra-oral photos to help patients understand their treatment needs and highlight the changes that have been made to their smile. These photos are also used to show other patients, in the office, of what their potential outcomes could be. Dr. Sam does not and will not use any photos that can give away a patients image. Close up shots of teeth only are used for in-house and Huntline Dental website promotional items. For example, before and after photos shown chairside to new patients, photos used on TV in waiting room, photos used on the monitors in the operatories, or images within our services section on the website . **If any full-facial or headshot photos are going to be used for public use, you will be asked for additional consent before Huntline Dental Group would use your images.**

"These photos are so important for patients that need to understand their treatment options, and have confidence in our ability to enhance their smile". —Dr. Sam.

As the owner of Huntline Dental Group, I ask for your consent to use the above described photos



HUNTLINE DENTAL GUARANTEE!

We want our patients to feel secure in their decisions for treatment. Our "Crowns" or "Caps", as they are commonly called, come with a **Lifetime Guarantee Against Fracture.** If your crown breaks we will fix it at **no charge provided that you keep all recall check-up appointments** after your crown is completed. Your Check-Ups are due every six months—we will see you then!

Thank you for choosing Huntline Dental Group as your dental care providers. We look forward to many years of great service and friendship with you and your family.

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Patient/Guardian Signature Date

Huntline 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	☐	☐

Primary Care Doctor: **Sleep Doctor:**

Dental Exam Findings:
☐ Evidence of Bruxism ☐ Scalloping of the tongue ☐ Crowded airway
☐ Tori or Bone Loss ☐ Anterior wear ☐ Retrognathia / Class II