ANNMARIE OLSON, DDS, PA

restorative, cosmetic & sedation dentistry

Patient Name_____ DOB:_____

Mailing address_____

City_____ State_____ Zip_____ DL#:_____ Sex: **M F**

E-mail: _____ SSN: _____

Employer: _____ Occupation:_____

Work phone: _____ Home phone: _____

Cell phone: _____ Referred by: _____

Spouse name: _____ Spouse Employer: _____

If patient is a **MINOR**:

Mother: _____ Father:_____

Cell phone: _____ Cell phone:_____

EMERGENCY INFORMATION

Emergency Contact: _____ Cell phone: _____

Relationship: _____

DENTAL INSURANCE INFORMATION

Subscriber name: _____ Subscriber DOB: _____

Sub. ID# or SSN: _____ Group Name and #:_____

Relationship to patient: _____ Is there secondary coverage? **YES NO**

Insurance Company: _____ Ins. Co. Phone #:_____

DENTAL HISTORY

Date of Last Dental Visit: _____ Date of last COMPLETE x-rays taken: _____

Previous Dentist: _____ Phone:_____

Describe and indicate the location of any dental problems you are currently having:

_____

Are there any special dental topics which interest you such as cosmetic dentistry, periodontal (gum) disease, etc.?

_____

What is the most important thing that we can provide for you? _____

11623 Angus Road, Suite 23
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HEALTH HISTORY

Physician's name_____ Phone:_____
Date of last physical:_____ Weight:_____ Height:_____
Do you use tobacco products? YES NO If yes, how much per day?_____
If you are a woman, are you pregnant? YES NO If yes, how many weeks?_____
Are you currently taking any medication? YES NO If yes, please list:_____

_____
Are you allergic to any medications? YES NO If yes, please list:_____
Any other health issues? YES NO _____
Do you take an antibiotic before dental procedures? YES NO _____

Circle any of the following which you had or have at present:
(Please indicate dates next to items circled)

Rheumatic Fever	Seizures	_____/_____
Heart Disease	Diabetes	_____/_____
Heart Surgery	Tuberculosis	_____/_____
Pacemaker	AIDS/HIV	_____/_____
Heart Murmur	Anemia	_____/_____
Artificial Knee/Hip	High Blood Pressure	_____/_____
Fainting Spells	Blood Disorder	_____/_____
Hepatitis Type?	Drug/Alcohol Addiction	_____/_____
Jaundice or Liver Disease	Blood Transfusion	_____/_____

	YES	NO
Are you apprehensive about dental treatment?	Y	N
Do you routinely use GAS (Nitrous Oxide)?	Y	N
Do your gums bleed when brushing/flossing?	Y	N
Have you had PERIODONTAL surgery/therapy?	Y	N
Do you have loose or shifting teeth?	Y	N
Do you currently have cold or canker sores?	Y	N
Do you have any HOT or COLD sensitivity?	Y	N
Are you unhappy with the appearance of your smile?	Y	N
Do you grind or clench your teeth?	Y	N
Do you have frequent head/ear/neck aches?	Y	N
Do you think you snore?	Y	N
Do you think you have sleep apnea?	Y	N
Does your jaw pop or click while opening/eating?	Y	N
Have you had TMJ (jaw joint) therapy?	Y	N
Have you worn braces in the past?	Y	N
Do you wear partials or dentures?	Y	N
Do you think you currently have decay?	Y	N
Do you think you currently have gum disease?	Y	N
Do you think you currently have a dental infection?	Y	N

CONSENT:
The undersigned hereby authorizes AnnMarie Olson, D.D.S. and her team to take X-rays, models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment and therapy that may be indicated. I understand the use of anesthetic agents embodies certain risk.

_____ _____ _____
PATIENT SIGNATURE DATE DOCTOR SIGNATURE

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Office Procedures and Protocol

Our team would like to extend a warm welcome to you. We realize you choose where you go for your health needs, and we are honored to have you in our office. Our goal is to provide you with honest, caring dental excellence in an exceptionally comfortable and professional environment. We are always looking for ways to improve your experience in our office, and we welcome your feedback. In order to provide you with excellent service and to avoid any misunderstandings, we feel it is important our patients be clearly informed of our office policies.

Payment options: All fees, services and treatment will be explained to you prior to each appointment. Your payment in full is due at or before the time of your appointment. For your convenience, we accept all major credit cards, CareCredit, cash and checks.

Financial policies: All account balances are considered past due after 30 days. A $30.00 service fee will be added for any returned checks, and this fee plus the original amount of the check may be recovered electronically. After a returned check, only cash or credit cards will be accepted for payment, and appointments must be paid for in advance.

Financing options: We wish for all our patients to have access to the care they need. We are proud to help make this possible by offering financing (in many cases, interest-free) through our partnership with CareCredit and Wells Fargo Health Advantage Program. We're happy to provide you with more details if you're interested.

Appointment policy: Your appointment is reserved especially for you. Broken appointments represent a cost to you, to us, and to our other patients who are waiting for care. Please **call** our office during business hours (Mon.-Thurs. 9:00am- 5:00pm and Fri 9:00am-3pm) with 48 hours of notice to reschedule any appointments. We send confirmation emails or text messages for your convenience. Replying to these methods to change is not considered effective notice. You must **call** the office to reschedule an appointment. Of course, we understand emergencies do occur. However, excessive abuse of this policy (more than twice) will result in additional charges to your account, payment for the amount of your missed appointment, requiring payment in full for appointments before any new appointments can be made, or dismissal from the practice. Initials:_____

We kindly ask that parents please accompany any children under the age of 16 to all dental appointments and remain in the office for the entire appointment. Initials: _____

Patients without dental insurance: Dr. Olson and her Associates offer an in-house discount plan called the Smile Plan. Please ask our front team for details.

Patients with dental insurance: We do work with many insurance companies, however, Dr. Olson and her Associates are "in network" with Cigna, Sun Life Financial, United Concordia, and Aetna. We will research your plan to the best of our ability in order to present you with an ESTIMATE of what your

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insurance might cover. If we are "in network" with your insurance company, we have an obligation to only charge up to an allowed amount that we have agreed upon with your insurance company.

If we are considered "out of network," the insurance company will either allow PPO fees (sometimes rather low) or go by "reasonable and customary" fees. Reasonable and customary fees are determined when an insurance company surveys a geographic area and finds the average fee. They will then pay a percentage of that fee. The fee amount depends on the provisions of your plan.

You pay us the **portion** we estimate will not be covered by insurance, at the time of your appointment.

You will still have an estimated balance that we will wait for your insurance to pay.

Credit Card Authorization: We prefer to keep your credit card on file. We can balance bill your card any remaining portion not paid by your insurance company. We can also **credit** your card if you end up with a credit on your account.

We will always notify you prior to any transaction.

Card number:_____ **Exp. Date:**_____

Security code:____ ____ ____ **Type: VISA M/C AMEX DISC**

Cardholder's signature_____

Secondary Insurance: We recognize some patients are covered by two dental insurance companies. We are happy to file your secondary insurance as a courtesy to you. When we file your secondary insurance we will request that they reimburse you directly. We will collect your estimated portion based on your primary insurance coverage.

A friendly note about insurance: Your insurance plan was negotiated between you/your employer and the insurance company, and coverage often changes from year to year. There are thousands of plans and therefore it is impossible for us to know exactly what your insurance MIGHT pay. Account balances are the responsibility of each patient, not our office or the insurance company.

Thank you for taking the time to read and accept our policies. Please always let us know if there is anything we can do to better serve you. We greatly appreciate your understanding and cooperation!

Agreement: I, _____**, have read and understand the above policies, and agree to their terms.**

Signature: _____ **Date:** _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

You May Refuse To Sign This Acknowledgement

I, _____, have been provided with a copy of this office's Notice of Privacy Practices.

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

___ Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please specify) _____

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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	☐	☐

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