Welcome to a whole new level of oral health care! Our practice is like no other you have ever been to. We are a general dental office that focuses on comprehensive care. We believe in helping our patients develop a personalized oral health plan that will help them improve their overall health and optimize their oral health for their lifetime. So that we can best serve you and your specific needs, we ask you to complete these comprehensive forms.

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

E-mail: _____

Birthdate: _____ Age: _____

Occupation: _____

Employer: _____

Business Address: _____

City: _____ Business Telephone: _____

Person responsible for this account: _____

Is another member of your family a patient at our office? _____

Whom may we thank for referring you? _____

Person to contact for an emergency? _____

Phone #: _____

Appointments are confirmed via

☐ Text message ☐ e-mail ☐ Both (please check your preference)

YOUR SPOUSE (For insurance reasons)

Name: _____

Occupation: _____

Employer: _____

Business Address: _____ City: _____

Business Phone: _____ Cell: _____

INSURANCE INFORMATION

Primary Carrier:

Insurance Co.: _____

Address: _____

Employer: _____

I.D. #: _____

Group #: _____

Relationship to insured: _____

Insured SSN: _____

Insured Birthdate: _____

Your SSN if different: _____

Secondary Carrier:

Insurance Co.: _____

Address: _____

Employer: _____

I.D. #: _____

Group #: _____

Relationship to insured: _____

Insured SSN: _____

List all medications, prescription and non-prescription, that you are currently taking:

Name:	**Dosage:**	**Reason:**

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ Date: _____

MEDICAL HISTORY

Please check YES or NO for each history question.

Are you under a physician's care now? ☐ YES ☐ NO if yes, please explain: _____

Have you ever been hospitalized? ☐ YES ☐ NO if yes, please explain: _____

Have you ever had a major operation? ☐ YES ☐ NO if yes, please explain: _____

Are you taking any medications, pills, drugs? ☐ YES ☐ NO if yes, please explain: _____

Have you ever taken Phen-Fen or Redux? ☐ YES ☐ NO if yes, please explain: _____

Have you ever taken Fosomax, Boniva, Actonel or any other medications containing Bisphosphonates? ☐ YES ☐ NO if yes, please explain: _____

Have you ever had a serious head/neck injury? ☐ YES ☐ NO if yes, please explain: _____

Are you on a special diet? ☐ YES ☐ NO if yes, please explain: _____

Do you use tobacco? ☐ YES ☐ NO if yes, please explain: _____

Do you use controlled substances? ☐ YES ☐ NO if yes, please explain: _____

Women: Are you

Pregnant / Trying to get pregnant? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO

Are you allergic to any of the following? (please circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs Other:

Do you have, or have you ever had any of the following:

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

Have you ever had any serious illness not mentioned here? Explain: _____

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 _____ Date: _____

Our office is like no other dental office. This could be the most important dental visit you will ever have. We believe that helping you determine your present and future dental needs is the most important service we offer. Here are some topics we will be discussing. Although these are issues you have probably never thought of in detail, please answer the following to your best ability . . . thank you!

- **What is the main purpose of your first visit and what would you like to get accomplished?** _____

_____

_____

- **Briefly mention any positive or negative aspects of your previous dental visits** _____

_____

_____

- **What do you already know about our office and what are your expectations?** _____

_____

_____

Treatment Recommendations or Treatment Options?

Instead of making recommendations to you based on how we would like to see you choose, we would prefer to offer you treatment options, based on how you would like to take care of your dental health.

The following questions help us determine what is important to you, please rate on the following scale from 10 to 1.

1. **How (dental) healthy would you like to be?**

(10) (9) (8) (7) (6) (5) (4) (3) (2) (1)

10 (healthiest) 1 (not a concern at this time)

2. **Almost all dental problems are predictable and preventable. In order to not overwhelm you with excess details, how preventative (or proactive) would you like to be regarding dental disease?**

(10) (9) (8) (7) (6) (5) (4) (3) (2) (1)

10 ("nip it in the bud early") 1 (wait until it hurts)

3. **How important are dental cosmetics to you?**

(10) (9) (8) (7) (6) (5) (4) (3) (2) (1)

10 (very important) 1 (not important)

Because the teeth and bite support the face and its overall appearance, there is an intimate relationship between tooth size, shape and position with lip and face support, wrinkles, and visual age appearance.

4. **How important is facial cosmetics to you?**

(10) (9) (8) (7) (6) (5) (4) (3) (2) (1)

10 (very important) 1 (not important)

Anything else you would like to mention? _____

_____

_____

_____

DENTAL HISTORY

Please indicate an answer for each general question.

How often do you brush: _____ How often do you floss: _____

Toothpaste you use: _____ Mouthwash you use: _____

Other oral health care aids you currently use (waterpik, electric toothbrush, tongue scraper, etc.)

_____

Date of last Dental Exam: _____ Date of last cleaning:_____

Do you currently have any dental pain? Yes / No. If yes, where: _____

If yes to above, is the pain: sporadic / constant

dull / sharp

Do you have any other current dental concerns/comments? _____

Do you now, or have you ever: (please circle)

Grind Teeth:	PRESENT	PAST	NEVER	Bite Nails:	PRESENT	PAST	NEVER
Bite Cheek:	PRESENT	PAST	NEVER	Smokeless Tobacco:	PRESENT	PAST	NEVER
Tongue Thrust:	PRESENT	PAST	NEVER	Thumb/Finger:	PRESENT	PAST	NEVER
Mouth Breather:	PRESENT	PAST	NEVER	Toothpick/Stimulator:	PRESENT	PAST	NEVER
Bulimia/Anorexia:	PRESENT	PAST	NEVER	Chewing Gum:	PRESENT	PAST	NEVER
Cigar/Cigarette:	PRESENT	PAST	NEVER	Candy:	PRESENT	PAST	NEVER
Pipe:	PRESENT	PAST	NEVER	Soft Drinks:	PRESENT	PAST	NEVER

Are your teeth sensitive to: (please circle)

Hot or cold:	PRESENT	PAST	NEVER
Biting/Chewing:	PRESENT	PAST	NEVER
Sweets:	PRESENT	PAST	NEVER

Have you ever had: (please circle)

Orthodontic Treatment:	PRESENT	PAST	NEVER
A Bite Plate or Guard:	PRESENT	PAST	NEVER
Periodontic Treatment:	PRESENT	PAST	NEVER
Oral Surgery:	PRESENT	PAST	NEVER
Serious injury to mouth or head:	PRESENT	PAST	NEVER

Is there anything about your teeth or smile that you don't like or would like to change? _____

_____

_____

_____

Is there anything else about your teeth or dental history that you want us to know? _____

_____

_____

_____

CONSENT FOR MYSELF OR MINOR PATIENT:

The undersigned hereby authorizes Doctor Carson and employees to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor Carson to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor Carson to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with above referenced patient and further authorize and consent that Doctor Carson choose and employ such assistance she 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.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ Date _____ Witness _____

Responsible Party for Minor Patient _____ Relationship to Patient: _____

TMJ and Sleep Screening Form

Check all that apply:

- ☐ Frequent Snoring
- ☐ Sleep Apnea
- ☐ Daytime Fatigue
- ☐ Told that I "stop breathing" during sleep
- ☐ Headaches and/or Migraines
- ☐ Ear Congestion
- ☐ Pain Behind the Eyes
- ☐ Vertigo (dizziness)
- ☐ Tinnitus (ringing in the ears)
- ☐ Limited Mouth Opening
- ☐ Neck, Shoulder or Back Pain and/or Stiffness
- ☐ Loose Teeth
- ☐ Clenching/Bruxing
- ☐ Clicking or Grating Sounds in Jaw Joint(s)
- ☐ Pain or Soreness of Jaw Joint(s)
- ☐ Locking Jaw (opened or closed)
- ☐ Tender, Sensitive Teeth
- ☐ Thermal Sensitivity (hot or cold)
- ☐ Difficulty Chewing
- ☐ Difficulty Swallowing
- ☐ Trigeminal Neuralgia
- ☐ Bell's Palsy
- ☐ Postural Problems
- ☐ Tingling or Numbness in Fingers or Arms
- ☐ Nervousness/Insomnia

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

✔ Check one in each row:	**0 No chance of dozing**	**1 Slight chance of dozing**	**2 Moderate chance of dozing**	**3 High chance of dozing**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (i.e., a theater or a meeting)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopping for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____ (Add columns 0–3)

Kathleen Carson, DDS

To Our Valued Patients:

We would like to welcome you to our office. Please take a few moments to read the following with regard to our payment policy.

If you have no dental insurance, payment in full is required at the time of service.

If you have dental insurance, we will be happy to bill your insurance company for you. Your estimated patient portion of the fee will be due at the time of service.

We are not currently contracted with any HMO or DPO plans or dental groups. If your insurance is with an HMO or DPO plan, we will consider your account with us as "cash" and payable at the time of service.

Please understand that we cannot always discern from your insurance card the exact plan in which you are enrolled or the exact benefits that you are eligible for. You will need to be familiar with your dental coverage specifics. We always welcome questions and are available to help you understand your insurance if we can. If you need to make financial arrangements, please speak with us prior to your appointment time.

Thank you,

Integrative Dental Arts

I have read and understand the above material and agree to its standards.

Name_____

Signature_____Date_____

30200
AGOURA RD
SUITE 270
AGOURA HILLS
CALIFORNIA 91301
T (818) 889-0400
F (818) 889-9032
www.integrativedentalarts.com

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:

We submit a request for payment to your insurance company. The insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,

- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office, in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;

- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain;

- Abide by the terms of this Notice;

- Notify you if we cannot accommodate a requested restriction or request; and

- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to any of our office staff. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

- Notification
  Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death. You will also be set to receive text messages for appointment reminders and financial information. If you wish to decline receiving text messages from Agoura Hills Oral Surgery, please notify our office. Financial and planned treatment information will be communicated via text and or email unless you indicate otherwise. Message rates may apply.

- Communication with Family
  Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

- Food and Drug Administration (FDA)
  We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

- Workers Compensation
  If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

- Public Health
  As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- Abuse & Neglect
  We may disclose your protected health information to public authorities to report abuse or neglect.

- Correctional Institutions
  If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

- Law Enforcement
  We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

- Health Oversight
  Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

- Judicial/Administrative Proceedings
  We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

- Other Uses
  Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided. Our office is under 24 hour video surveillance.

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature Date

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

_____

to use or disclose the following health information.

☐ - All of my health information

☒ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

The purpose of this authorization is (check all that apply):

☒ - At my request

☐ - Other: _____

☐ - To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ - To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

This authorization ends:

☐ - On (date)_____

☐ - When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____

Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____