EVELYN Ascough DDS

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Acknowledgement of Office Financial Policy

We look forward to providing you with excellent dental care!

Our office is dedicated to providing optimal care for every patient and working with you to achieve that goal. We pride ourselves in helping you in any way and in continuing to provide the quality of care to which you have become accustomed.

We appreciate the respect that you show us by reading, signing, and observing our office and financial policies. Please understand that payment of your charges is considered part of your treatment.

Please let us know of you have any questions... it will be our pleasure to help you

IF YOU HAVE DENTAL INSURANCE:

In order to better serve you, we ask that you familiarize yourself with your dental benefits. Dental treatment is based on your oral health, needs, not on the type or amount of dental insurance you have. Dental insurance is a benefit provided to you by your employer to help offset the cost of your dental treatment, alternatively, some patients pay for their dental insurance on their own. The benefits you receive under the terms of the contract have been negotiated by the insurance company and your employer, and not by our OFFICE. We do not compromise your care based on constraints placed by the insurance. Although we strive to help explain dental plan issues to you, we may not be able to answer specific questions about your dental plan or predict what your level of coverage for a procedure will be. Insurance companies provide us only with estimates, because plans offered by the same employer or written by the same third party payer can vary according to the contracts involved.

WHAT WE DO FOR HELP: We will use all of your resources to get as accurate an estimate as possible for your treatment. We will inform you of your estimated share for the payment. As a courtesy to you, we will also compute and submit your dental

insurance for you. Because the insurance reimbursement process is often very complicated this is an estimate.

For all patients, regardless of insurance coverage:

- I understand that payment in full is expected at each appointment. PLEASE COME PREPARED FOR YOUR DEDUCTABLE, AND CO-PAYS AT THE TIME OF SERVICE.

- I understand that you accept cash, check, or credit cards (MASTER, VISA AMERICAN EXPRESS AND DISCOVER CARD). And that there will be a $5.00 billing charge per month if statements need to be sent, and payment is expected in 30 days.

- I understand that full responsibility for payment of **all** fees for dental services provided in this office for my dependents or me is mine, due and payable at the time services are rendered, regardless of insurance coverage.

- I understand that In the event of default, I (we) promise to pay legal interest on the indebtedness, together with reasonable attorney's fees and collection of this note. I understand that a LATE PAYMENT CHARGE may be assessed if my payments are not received by the DUE DATE. The amount of the late charge to be assessed will be 5% of the past due minimum payment.

- BROKEN APPOINTMENT CHARGE: I understand that when I schedule an appointment, the time is reserved exclusively for me, and that there will be a charge of $50.00 for hour's appointment FAILED and. rescheduling without 48 HOURS NOTICE.

- I authorize EVELYN G. ASCOUGH, DDS INC dental office to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/ or health practitioners, to the extent permitted under applicable law.

- I, the undersigned, certify that I have read and fully understand the above agreement and that all information that I have provided pertaining to my account is accurate and true to the best of my knowledge. Submission to treatment implies consent to financial responsibility.

_____ _____

Patient/ Signature Date

GETTING TO KNOW YOU

NAME:_____DATE:_____

What name would you like us to call you? _____

Please describe the reason for your consultation today:

_____

_____

How long has this been going on and what other events apply to today's visit?

_____

_____

Why have you decided to deal with this now?

_____

Have you consulted with any other dentists about this? Yes No If yes, what was discussed or done?

_____

_____

When was your last dental check up?_____

Who is your regular/previous dentist? _____

HAVE YOU NOTICED OR HAS ANY DENTIST OR HYGIENIST EVER SAID THAT YOU:

Have gum disease (gingivitis)	Yes	No	Lip or cheek biting	Yes	No
Grind your teeth	Yes	No	Loose/broken teeth/filling	Yes	No
Clicking or popping jaw	Yes	No	Food collection between teeth	Yes	No
Jaw pain or tiredness	Yes	No	Sores, blisters/Growth	Yes	No
Pain around ear	Yes	No	Bad breath	Yes	No

SENSITIVITY TO (Please circle): Cold Heat Sweets When biting or chewing

Would you like to know your options to: Improve your smile Look younger Keep your teeth

What are your priorities and what would you like to see done now?

_____

_____

Personal Information

Name_____Birthdate_____Social Security No_____

MAILING ADDRESS_____

MARITAL STATUS(Please Circle) Single Married Divorced Other

HOW OR WHO REFERRED YOU TO OUR OFFICE?_____

PHONES: Work:_____ Home:_____ Fax:_____

Cell: _____ Email:_____

OCCUPATION: _____

EMPLOYER & ADDRESS_____

SPOUSE'S OCCUPATION:_____

EMPLOYER & ADDRESS:_____

ACCOUNT RESPONSIBILITY IF SOMEONE OTHER THAN YOURSELF:

Name:_____Birthdate_____Social Security No_____

Mailing Address:_____

Daytime Phone:_____

CONFIDENTIAL HEALTH HISTORY

Patient Name:_____ Date of Birth:_____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
   Date of last medical exam? _____ Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain _____
   Date of last dental exam _____ Name of last treating dentist _____
6. Yes No Are you in pain now?
   If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please Circle)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine or Xylocaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicines	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

Please list: _____

VI. WOMEN ONLY

Yes No Are you or could you be pregnant?
If YES, what month? _____
Yes No Are you nursing?
Yes No Are you taking birth control pills?

VII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
_____
Yes No Have you ever been pre-medicated for dental treatment? If YES, why _____
Yes No Have you ever taken Fen-phen? If YES, when _____

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

.....

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name		Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender **Male** ○ **Female** ○	Neck Size +2 Male ≥16.5 +2 Female≥15.0
Height	Feet / Inches		**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Co-morbidities +1 for each Yes response

Score

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
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 lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Epworth Score **TOTAL** the values from all 8 questions, If 11 or less **Score = 0** If 12 or more **Score = 2**

Score

Frequency **0 - 1 times/week** **1 - 2 times/week** **3 - 4 times/week** **5 - 7 times/week**

On average in the past month, how often have you snored or been told that you snored?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?
Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?
Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Assign points for each of the first three responses

Signature	Area Code / Phone Number	**Total all 6 boxes from above** **If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)**	**Point Total**